VA WHISTLEBLOWERS: EXPOSING INADEQUATE SERVICE PROVIDED TO VETERANS AND ENSURING APPROPRIATE ACCOUNTABILITY

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

TUESDAY, JULY 8, 2014

Serial No. 113–78

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.fdsys.gov

U.S. GOVERNMENT PUBLISHING OFFICE
89–377 WASHINGTON : 2015

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

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CONTENTS

VA WHISTLEBLOWERS: EXPOSING INADEQUATE SERVICE PROVIDED TO VETERANS AND ENSURING APPROPRIATE ACCOUNTABILITY

Tuesday, July 8, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 7:33 p.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Flores, Runyan, Benishek, Huelskamp, Coffman, Wenstrup, Walorski, Jolly, Michaud, Takano, Brownley, Titus, Kirkpatrick, Ruiz, Negrete McLeod, Kuster, and O'Rourke.

Also present: Representative Price.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. Good evening, everybody. This hearing will come to order. I want to welcome everybody to tonight's hearing entitled "VA Whistleblowers: Exposing Inadequate Service Provided to Veterans and Ensuring Appropriate Accountability." I would also like to ask unanimous consent that Representative Tom Price, from the great State of Georgia, be allowed to join us here on the dais and participate in tonight's hearing. Without objection, so ordered. Oop, I think I heard an objection.

Tonight we'll hear from a representative sample of the hundreds of whistleblowers that have contacted our committee, seeking to change the VA to improve patient safety and better serve veterans who have served our great Nation. We'll also hear from the Office of Special Counsel regarding its work protecting VA whistleblowers and the vital information that they provide. Representatives of VA will also be here to answer for the Department's reprisals against whistleblowers and its continuing failure to abide by its legal obligation to protect employee rights to report waste, fraud, and abuse and mismanagement to the Inspector General, to the Counsel, to Congress, and to this committee.

It's important to emphasize that the national scandal regarding data manipulation of appointment scheduling did not spring forward out of thin air at the Department of Veterans Affairs. Deceptive performance measures that serve as window dressing for automatic SES bonuses have been part of the organizational cesspool at the Department for many, many years. Instead of being a customer-driven Department dedicated to veterans, the focus instead

has been on serving the interests of the senior managers in charge. The manipulation of data to gain performance goals is a widespread cancer within the VA. We have often heard that VA is a data-rich environment, but when data is exposed as vulnerable to manipulation it cannot be data that is trusted.

Until recently, VA would continue to trot out the tired canard that patient satisfaction exceeds the private sector. That may be true at a few select VA centers. However, as our colleague Mr. O'Rourke demonstrated through local polling, such results have been over generalized. Moreover, during the course of the past year this committee has held a series of hearings showing a pattern at VA of preventable patient deaths across the country, from Pittsburgh to Augusta, to Columbia, to Phoenix. VA's satisfaction results are refuted by these tragic outcomes.

In every one of these locations whistleblowers played a vital role in exposing these patient deaths at the Department. Whistleblowers serve the essential function of providing a reality check on what is actually going on at the Department. At great risk to themselves and their families, whistleblowers dare to speak truth to power and buck the system in VA designed to crush dissent and thereby alter the truth.

Tonight we're fortunate to have three distinguished physicians testify with regard to their experiences in the VA. We'll also hear from a conscientious program manager in VA's National Health Eligibility Center who will show that the disease of data manipulation may have spread to the initial eligibility determinations for medical benefits. None of these whistleblowers lost sight of the essential mission of the VA—that mission to serve veterans. They understand that people are not inputs and outputs on a central office spreadsheet. They understand that metrics and measurements mean nothing without personal responsibility. Unlike their supervisors, these whistleblowers have put the interests of veterans before their very own interests.

Unfortunately, what all of these whistleblowers also have in common is the fear of reprisal by the Department. They will speak of the many different retaliatory tactics used by VA to keep employees in line. Rather than pushing whistleblowers out, it is time that VA embraces their integrity and recommits itself to accomplishing the promise of providing high quality health care to America's veterans.

In order to make sure there is follow through at VA, I have asked my staff to develop legislation to improve whistleblower protections for VA employees, and I invite all the members of this committee to work with us towards the end.

With that, I now yield to my good friend and ranking member, Mr. Michaud, for any opening remarks that he may have.

[THE PREPARED STATEMENT OF CHAIRMAN JEFF MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF MIKE MICHAUD, RANKING MINORITY MEMBER

Mr. MICHAUD. Thank you very much, Mr. Chairman.

This committee has held many hearings over the last years on problems with access to VA health care. At each of these hearings, problems were disclosed and the VA promised to improve, but little has changed. VA is widely known to have a culture of denying problems and not listening to feedback, be it from Congress, veterans, or its own employees.

The Department of Veterans Administration has had a reputation as being intolerant of whistleblowers. So far in this fiscal year, nearly half of the matters transmitted to agency heads by the Office of Special Counsel, 7 out of 15 involved the VA. According to the OSC, it currently has 67 active investigations into retaliation complaints from VA employees and has received 25 new whistleblower retaliation cases from VA employees since June 1 of 2014.

A recent New York Times article stated that within the VA there was a "culture of silence and intimidation," end of quote. Acting Secretary Gibson recently stated that he was deeply disappointed, not only in the substantiation of allegations raised by the whistleblowers, but also in the failures within the Department to take whistleblowers' complaints seriously.

Within VHA, the problem of intimidation and retaliation may be magnified by what some consider a protective culture of the medical profession. It is often thought to be against the code to point out colleagues' mistakes or where a nurse or attendant is told it is not appropriate to question a physician or surgeon. The natural tendency is to close ranks, to deny that problems exist or mistakes were made.

So after we listen to the testimony before us this evening from the whistleblowers, the Office of Special Counsel, and the VA, will anything change after we hear what the whistleblowers have to say, and how do we fix this culture and encourage all VA employees to step forward to identify problems and work to address those problems?

Changing a culture is not easy. It cannot be done legislatively and it cannot be done by throwing additional resources at it. Talk is cheap. Real solutions are hard to find. It is clear to me that the VA as it is structured today is fundamentally incapable of making real changes in the culture.

I note that Acting Secretary Gibson announced today that he was taking steps to restructure the Office of Medical Inspector by creating a, quote, "strong internal audit function which will ensure issues of the quality care and patient safety remains at the forefront," end of quote. This is an improvement, but it raises additional questions regarding how these restructures will better enable OMI to undertake investigations resulting from whistleblowers' complaints forwarded by the OSC, or how will it also have the authority to ensure that medical actions will be taken to the appropriate components of the VA?

Time and time again, as the June letter from OSC demonstrates, the VA found fault, but determined that these grave errors did not affect the health and safety of veterans. Anyone reading the spe-

cifics of any of these cases will find that this harmless error conclusion, as stated by the OSC, to be a serious disservice to the veterans who received inadequate patient care for years. I agree that the OSC June 23 letter, and it quotes, "This approach has prevented the VA from acknowledging the severity of the systematic problems and from taking the necessary steps to provide quality care to veterans," end of quote.

We all seem to have some goals this evening. We all want the VA employees to feel comfortable raising problems and having them addressed without fear that raising their voices will mean the end of their careers. The VA has stated that it wants to make fundamental changes in its culture so that the workforce intimidation and retaliation is unacceptable. Talk is cheap. Real change is difficult.

I would propose that the very first order of business at the VA is to take accountability seriously. If any VA employee is shown to have intimidated or retaliated against another VA employee, then that employee should be fired. The VA should have zero tolerance for policies that would harm whistleblowers and intimidate whistleblowers or retaliate against whistleblowers. As I see it, effective leadership and real accountability is the only way to begin the process of institutional changes, and I hope tonight is the beginning of that change.

And with that, Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. Thank you very much to the ranking member.

[THE PREPARED STATEMENT OF HON. MIKE MICHAUD, APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much to the Ranking Member. I would ask that all members would waive their opening statements, as is the custom of this committee.

Thanks to the witnesses that are here at the witness table tonight. Our first panel that we're going to hear from is Dr. Jose Mathews, former Chief of Psychiatry at the St. Louis VA Health Care System; Dr. Christian Head, Associate Director, Chief of Staff, Legal and Quality Assurance, at the Greater Los Angeles VA Health Care System; Dr. Katherine Mitchell, Medical Director for the Iraq and Afghanistan Post-Deployment Center at the Phoenix VA Health Care System.

And at this time I'd like to introduce our colleague, Dr. Price, to briefly introduce his constituent, who will be the fourth witness on the panel this evening.

Mr. PRICE. Thank you, Mr. Chairman. I want to thank you and the ranking member for allowing me to offer this introduction. This is a remarkably important topic, and I commend the committee for the work that you've done.

As a physician, I worked at the VA hospital in Atlanta, as a matter of fact, for a number of years during my training, and I know how important it is to have honest and real information for our veterans to honor their service, which is why I am so very pleased to offer Scott Davis, Mr. Davis, who will be on the panel today. He is a resident of my district. He is a graduate of Morehouse College. His father served in Vietnam.

Mr. Davis is a program specialist at the VA's National Health Eligibility Center in Atlanta. He's been in contact with my office for a number of months outlining his concerns. He's come forward with the allegations and concerns that he has in a very brave and courageous manner. He's put his career and reputation on the line, and I have no doubt that his testimony tonight will help shine a light on the situation at hand. We must know the facts on the ground in full before we can truly begin to fix the untenable situation at the VA.

So I welcome Mr. Davis, and I thank you for allowing me to join you for this introduction.

The CHAIRMAN. Thank you very much, Dr. Price. We appreciate you joining us here this evening.

I appreciate the testimony of the witnesses today and look forward to working with all of you to find a solution for our veterans.

I would ask the witnesses if you would please rise. Raise your right hand.

[Witnesses sworn.]

The CHAIRMAN. Thank you. Please be seated. All of your complete written statements will be entered into the record.

And, Dr. Mathews, you are now recognized for 5 minutes.

STATEMENT OF JOSE MATHEWS, M.D.

Dr. MATHEWS. Honorable Chairman and distinguished members of the committee, I am honored to appear before you today to speak about my experiences while serving in the capacity as the Chief of Psychiatry with the Department of Veterans Affairs in St. Louis, Missouri, and in the capacity of the detail when I was removed from this position. I just want to very briefly outline the goals I had when I took this position as the Chief of Psychiatry, leaving my full-time faculty position at Washington University.

I had very simply wanted to create the very best care possible with the resources I had. And very soon I realized that the metrics I had, that the VA was putting out, was not reflecting what I was actually seeing. I had made it a point that I'd review every veteran complaint, and the majority of the veteran complaints I had its had to do with their inability to obtain care at a reasonable time, the long wait times, having difficulty even contacting the clinic to schedule an appointment.

So I started out with a very simple question as to how busy are we really at the outpatient clinic. And the answer I got was not very good. I got the answer that I verified that the psychiatrists were only spending approximately 3.5 hours in direct patient care. I could not account for the rest of their time. I verified this. I put this data transparently as prospective data where any psychiatrist could challenge me and ask me question whether that was accurate or not, and I did not get one valid question.

So I knew that the data was accurate, I discussed this with the Chief of Staff, and I wanted to change this. There were two things that I wanted changed. One was that the veteran has easy access to care, timely access to care. And the second was that no veteran would be turned away if they come to the clinic. I had a very sad veteran complaint about a disabled veteran who had requested his

friend to drive because he does not drive. He drove approximately an hour and a half to come to the clinic. He had two requests. He wanted to see his provider earlier because he was not doing well and he wanted his medications refilled.

Unfortunately, that veteran had neither of these requests met. He was sent away with another appointment 48 days later, and his medications were not refilled. And just before this meeting I checked, and that veteran, unfortunately, is lost to follow-up, has not come back to the clinic since last May. And his description of that event includes how disappointed and how upset he is at the VA for not providing him care.

So that was the context of how I started out. I discovered that the physician time was not being utilized properly. There was long wait times. And one of the metrics that's very important is, especially in mental health, is engagement and care or the dropout rate, and what I found was there were 60 percent of the veterans were not coming back for their visits in the outpatient setting. So there was 60 percent attrition rate.

So there were only four pieces of information that I needed to provide very good care. One was the wait time to care. The second was the utilization of expertise or what amount of time does a physician actually expend in direct patient care. The third was the retention in care, how many veterans actually follow up with care or dropping out of care. And the fourth metric, that was not existent, is the veteran's satisfaction with care.

Like Chairman Miller talked about these surveys not being complete and may not be reflective of all places, I wanted the survey to be a complete set. So I talked to some donors who I knew from Washington University, and they pledged $60,000 over 2 years to institute a real time veteran satisfaction survey. So I had the contract, the educational contract for iPads, I had logged in people to program valid questionnaires in it, and my intent was that while a veteran is waiting in the waiting area to be seen would be able to complete this questionnaire using touch screens, which would be automatically compiled, and I would have information on whether a particular clinic or a particular healthcare professional I need to focus on.

So this last bit was very concerning to the staff, and shortly after I made these disclosures, including two avoidable deaths, that I wanted root cause analysis on and an inpatient suicide attempt while the joint commission was reviewing our hospital, which was completely covered up, and I did not go along with that. So very shortly I was put on detail. I was told that there would be an administrative investigation and that I was put to compensation and pension, doing compensation and pension evaluations.

Now, I took this job, also it was dealing with veterans, I'd filed the complaint with OSC, and while they were processing my complaints I took this very seriously, to evaluate the veterans for whether they had compensate mental disorders related to their service. And what I found again here was that in many instances the veteran was not even heard properly. I had doubts whether the prior evaluation report was the same veteran or not, and this was a serious concern, so I actually started to look at their IDs again to make sure that this was not some other person.

And the problem here was that the veterans did not have enough time to explain their situation. It was a hurried, conveyer belt-like system where I was specifically told that I was spending too much time with the veteran, that I should hurry up and see the veteran and just check a few boxes in my evaluation because it's meant for some rater somewhere to rate the disability. But that's not how I saw my job, and I think that's not the right way to do it. The three competency to be accomplished in these evaluations, because these are disability evaluations: You have to make sure that the veteran is heard properly, and the second thing is that I review the prior records properly to make sure that I capture a full history, and then the third is to make sure that my report reflects some of the inconsistencies in the record and I speak to it, so that the very next person, if it becames an appeal issue, can determine how I made my decision.

Now, there were a few egregious errors that were there, and that really bothered me, and as I was detailed under primary care. So I wrote to the Chief of Primary Care recently about these examples, about why this was really unfair to the veteran and how it affected the life of the veteran. And just 2 weeks ago, on the 26th of June, I'm detailed now to another place.

So from my perspective, I have always put the veterans' interests first, and I have disclosed, I have disclosed the wrongdoings that I found promptly to the Chief of Staff and to the Chief of Mental Health with the expectation that they would address it. And what I have found is that nothing has really changed. As late as June, just 2 weeks ago, the response to my finding about these evaluations that were not done properly was to just detail me elsewhere.

So this seems to be an ongoing practice. When it's detailed I don't have any responsibility of the Chief of Psychiatry. That's the position I accepted. Two people who I really worked hard on recruiting, both excellent psychiatrists, one trained at Hopkins, the other at Harvard, they both declined to join the VA after I had to disclose that I'm no longer the chief, I've been removed.

So there's a sense of mission that's lacking, and I'm really hoping that this committee with its powers will take aggressive actions to really make sure that this retaliation stops and that the people responsible are held accountable, because really, with the data being so cooked up and so unbelievable, it's extremely important that, while we work on data integrity, to make sure that the data reflects reality, it's extremely important that people step forward and are able to speak the truth and talk about what's really happening at the patient interaction level. I'm really hoping that this committee would do that, and I'm really honored that I have this opportunity to be able to answer questions and to be here.

The CHAIRMAN. Thank you, Dr. Mathews. We'll have an opportunity, each of us, to ask questions and get into specifics a little bit later on.

[THE PREPARED STATEMENT OF DR. JOSE MATHEWS, APPEARS IN THE APPENDIX]

Next I'd like to recognize Dr. Head for 5 minutes.

STATEMENT OF CHRISTIAN HEAD, M.D.

Dr. HEAD. Thank you for inviting me to testify today. I'm honored, Congressman. And I think it's a very important topic, our veterans, and we shouldn't lose focus of that. I'm Associate Director/Chief of Staff at the West Los Angeles VA Hospital. I'm very proud of my position, and I can't think of a better job than serving our veterans.

But retaliation is alive and well across our country, especially within the VA Administration. My first encounter was a number of years ago. I was subpoenaed by the Inspector General to investigate time card fraud involving two surgeons in my area. I was among close to 30 individuals who gave testimony. I gave honest and true testimony. And during that testimony I said I feared retaliation, and I outlined how I felt they would retaliate against me.

Every aspect I outlined came true. The person who did the deposition was Inspector Solomon from the Inspector General's Office, and she promised I would be protected both from the State and Federal Government. Three months after they came out with the final results, one of the individuals was paid back a year's salary to the Federal Government and resigned. Another individual who they recommended immediate termination was allowed to stay in her supervisory role.

There was an end-of-the-year party because we're affiliated with a university that's nearby. At that party, this slide was shown.

[Slide]

Dr. HEAD. I know. That actually is me. I'm much younger back then, and I had hair. But you see I'm flipping the bird, and it says, "If all else fails, call 1–800–488–VAIG." In front of close to 300 individuals, I was labeled a rat. I was labeled the person who ratted out this person.

The slide that followed this is so heinous that I can't even show or discuss it today. I could discuss it under subpoena. That person, by the way, is still in the supervisory role at the VA. No apology, nothing.

I somehow survived that. Retaliation has been relentless. The problem my retaliators have is that I think the VA and the veterans deserve far better. No matter what happens to me, I think the focus still should be on the veterans of this country.

I somehow survived that process, and again I was retaliated again later when I gave my opinion on the investigation of a physician who was wrongly terminated. I was asked to change my testimony. I stopped getting paid for two weeks. And because of a number of other factors, my house went into foreclosure. I didn't lose my house, but the harm it causes the family members of Federal workers who are being retaliated against cannot be measured. I have two young girls who I would be proud if they decided to join the Armed Forces or even work for the VA.

I think the VA has the potential to be one of the finest institutions in the world. We have seen certain aspects. The pharmacy cannot be matched. It's one of the best in the world. Very efficient. There are many different things that are efficient within our system, but what we should ask ourselves. When someone came up with the idea of seeing a veteran in 14 days, that actually sounded

like a good idea, that a veteran should be seen promptly. What we should be questioning is, if we made a mistake and somehow overloaded the system, how come people's names disappeared off lists? How come hundreds of thousands of veterans electronically no longer existed? That should be the question.

Retaliation exists because there's a culture. This culture of retaliation, that's really the cancer to the Veterans Administration. Most physicians and nurses and people who work in the hospital are disgusted. Morale is extremely low. People come up to me all the time and say, did that happen here? People care. When I heard some of the testimony from the Phoenix VA, it was gut-wrenching, I couldn't sleep. And I believe there's a lot of people within the VA system that feel the same way.

But there exists a cancer within leadership, a few individuals that perpetuate this idea that we should be silent, that we shouldn't stand up and do the right thing and be honest. Everyone makes mistakes. But when you make a mistake and you try to conceal it, that is really the question we should be asking. Who are these individuals who would alter data and hide the truth and prevent patient care?

I've been receiving text messages all day from veterans saying, be careful, Dr. Head, we don't want to lose you as a surgeon. Be careful, something might happen to you. If you get labeled as a whistleblower, oh, my God, they'll take you out. I'm not afraid to be taken out. I do hope if I am taken out someone will take care of my family. But I think people need to speak up. And we shouldn't be isolated, ostracized.

And the level of defamation, you notice that every time there's a whistleblower there's usually an email that follows: Well, this person is not getting a bonus and so they're upset. Or this person didn't get the raise they wanted, so they can be suspect. Or this person didn't do this. They always defame. They defame. They isolate. Usually they transfer you to another position. Why? Because they're slowly building a case, if they don't have one already, to say that you're crazy, that you're not being truthful.

And I would hope—I apologize for running over—I would hope that—I've given you close to 176–276 pages, I think, of evidence and a number of other statements of other individuals that would be helpful in trying to improve the system—I would hope—and especially the press, I will challenge you also to be a real reporter and actually report the truth—but also—not to insult the reporters—and also the Congressmen and Congresswomen, this is very important, that we try to focus on what's really important here, and that's the veterans of this country.

Thank you.

The CHAIRMAN. Thank you very much for your courage, Dr. Head.

[THE PREPARED STATEMENT OF DR. CHRISTIAN HEAD, APPEARS IN THE APPENDIX]

The CHAIRMAN. Dr. Mitchell, you're recognized for 5 minutes.

STATEMENT OF KATHERINE MITCHELL

Dr. MITCHELL. Good evening. I am deeply honored by the committee's invitation to testify tonight.

As a Phoenix VA employee, I have suffered retaliation for years for routinely reporting health and safety concerns. My written testimony details some of that retaliation and the devastating effects on patient care. In addition, section 4 and section 5 of my written testimony outline specific tactics that the VA uses to suppress whistleblowing and also to retaliate against anyone who speaks up within its ranks, even without whistleblowing. The VA, in my opinion, has routinely intimidated any employee who brings forth information that is contrary to the public image that the VA wishes to project.

In 2013, I submitted a confidential OIG complaint regarding the life-threatening issues within the Phoenix VA system. Approximately 10 days after the national VA received my report I was placed on administrative leave for a month. I was subsequently investigated for misconduct because I had provided limited amounts of patient information through the confidential OIG channel in order to support my allegations of the suicide trends and the facility's inappropriate response to them. Eventually I would receive a written counseling stating that I violated a specific patient policy, but to this day my human resources department refuses to tell me the name of the policy I violated.

This is relatively minor retaliation considering what happened during my last 3 years as Medical Director in the Emergency Department. During that time we were grossly understaffed in terms of physicians and nurses. In addition, there was insufficient ancillary staffing to do basic items such as wash beds, answer telephones, deliver patients, transport labs. As a result, doctors and nurses were routinely pulled away from direct patient care in order to perform these extra duties.

When the number of patient visits increased greatly to our ER, the deficiencies became obvious. The actual number of mistakes, as well as near misses, in our nursing triage skyrocketed. Symptoms such as stroke, heart attack, pneumonia, blood infections, and other serious medical issues were routinely missed by inexperienced triage nurses or by seasoned triage nurses who were simply overwhelmed by the flood of patients that were hitting our ER.

I started reporting the cases of actual mistakes or near misses to the facility chain of command. In the process of reporting hundreds of these, approximately 20 percent of the ER nurses would retaliate against me. They would stop doing my orders for patients. They would refuse to answer questions in the nurses station. They would not give me verbal reports on patients that were placed in rooms.

Administration was made aware of this and yet declined to intervene to stop this behavior that was obviously interfering with my care for patients. In addition, they ignored my repeated requests for additional resources for our ER, and they would never institute the comprehensive standardized nurse triage training that we needed in order to prevent future mistakes in care being made in our ER.

This is not to say they were idle however. They did ban me from reporting any cases to the Risk Management Department. My proficiencies dropped each year that I worked. I was forced to work 2 years of unlimited scheduled shifts to fill in holes in the physician staffing because HR was too slow at credentialing emergency room physicians to fill in.

Eventually things reached a critical mass. When the new oncoming Medical Center Director Sharon Helman arrived, I told her that the ER was too dangerous on an hour-to-hour basis to remain open and we should be closed unless additional vitally needed support was given. Unfortunately, the administration's response was to haul me into a meeting within about a week and a half and tell me that the only problem in the ER was my lack of communication skills. The nursing backlash that was reported would never be investigated.

Eventually I was involuntarily transferred based on critical need to an empty medical clinic. I assumed the medical director position of a clinic that only houses a social work program, and that's where I remain today. I do very useful work, but it's certainly not what I intended when I started reporting patient safety, health, and concerns.

The veterans needing care that presented to the ER have survived campaigns like D-Day, Iwo Jima, Chosin Reservoir, Tet offensives and counteroffensives, Desert Storm, Kosovo, Croatia, the battle of Fallujah, and dismal years in Helmand Province. It is a bitter irony to me that I as a physician could not guarantee their health and safety within a VA facility in the middle of cosmopolitan Phoenix.

The VA needs to embrace the core values that it advertises on its Web site. Administrators who place their own personal gain above the welfare of veterans need to face consequences for so doing. However, in the process it's very important that employees of any pay grade who truly care about veterans and their welfare, that they be protected. They were often placed in the unthinkable position of being forced to follow orders or else permanently lose their livelihoods and their ability to help any veteran in the future.

Most importantly, the ability to positively influence the patient care and safety of any veteran should not be considered a Democratic or Republican stance, a pro-union or anti-union choice, or even a uniquely American problem. The ability to freely advocate for the health and safety of any patient is a human issue, and it has ethical implications for all of us.

Thank you for your time.

The CHAIRMAN. Thank you very much, Doctor.

[THE PREPARED STATEMENT OF DR. MITCHELL, APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much Mr. Davis. Mr. Davis, you are now recognized for 5 minutes.

STATEMENT OF SCOTT DAVIS

Mr. DAVIS. Thank you, Mr. Chairman. I'd like to thank the committee for providing a platform so that the voices of VA whistleblowers can be heard. I urge the committee to take prompt action

as time is running out. Every day a window of opportunity closes on a veteran to receive quality health care because of the inaction of senior VA officials. Some veterans even face the burden of being billed for care their service has earned them.

As noted in the Office of Special Counsel report, VA leadership has repeatedly failed to respond to the concerns raised by whistleblowers about patient care at VA. Despite the best efforts of truly committed employees at the HEC and the Veterans Health Administration who have risked their careers to stand up for veterans, management at all levels have ignored them or retaliated against them for simply exposing the truth.

Some of the critical issues reported to senior VA officials by whistleblowers at the HEC include mismanaging critical veteran health programs and wasting millions of dollars on an Affordable Care Act direct mail campaign; the possible purging and deletion of over 10,000 veteran health records at the Health Eligibility Center; a backlog of over 600,000 pending health applications; nearly 40,000 unprocessed applications discovered in January of 2013. These were primarily applications from returning servicemembers from Iraq and Afghanistan.

The harassment I've experienced at the HEC from top levels of management include my whistleblower complaint to White House Deputy Chief of Staff Rob Nabors was leaked to my manager Sherry Williams, who stated in writing that she was contacting me on behalf of Acting Secretary Gibson and Mr. Rob Nabors. Neither Mr. Gibson nor Mr. Nabors have responded to this fact. My employment records were illegally altered by CBO Workforce Management Director Joyce Deters. I was illegally placed on a permanent work detail by Assistant Deputy Under Secretary Philip Matkovsky and Acting Chief Business Officer Stephanie Mardon. I was placed on involuntary administrative leave curiously at the same time the OIG investigation was taking place in Atlanta by Acting HEC Director Greg Becker.

Unfortunately, my experience is not unique at VA. Daron and Eileen Owens, who work at the Atlanta VA Medical Center, have experienced the same retaliation for reporting medical errors and patient neglect, as well as misconduct by senior VA police officials. Our Local 518 union president, Daphne Ivery, is routinely harassed as a direct consequence of assisting me and other disabled Federal employees with retaliatory actions by members of management. Mr. Owens, Mrs. Owens, Ms. Ivery are all veterans. And in fact, over 50 percent of the staff that works at the HEC are disabled veterans.

In 2010 allegations surfaced that applications for VA health care were being shredded at the HEC. Under the direction of the HEC Director and Deputy Director, Ms. Kimberly Hughes, former Associate Director for Informatics, and her team began to investigate this allegation. Her team discovered nearly 2,000 applications that were reported as being processed that did not appear as new enrollments in the enrollment system. Ms. Hughes' investigation was abruptly closed by the HEC Director's office. She was also subjected to harassment and intimidation because she dared to advocate for veterans.

The whistleblower statements I have provided to the committee were also provided to the OIG and are more relevant to the committee than many may realize. I urge additional review of those whistleblower statements. In addition to providing specific examples of whistleblower harassment to the committee, I hope my testimony provides some insight to three key issues VA management fails to address: Reckless waste of Federal funds and causing greater backlog of enrollment applications for the sole purpose of achieving performance goals; why there is resistance to implementing proper and effective processing and reporting systems, and the source of the resistance, as addressed previously by Dr. Draper during her testimony; and the need to remove ineffective managers, and the critical need for the VA Management Accountability Act to be fully implemented.

Thank you for this opportunity. I look forward to your questions.

The CHAIRMAN. Thank you very much, Mr. Davis.

[THE PREPARED STATEMENT OF MR. SCOTT DAVIS, APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much. And, Mr. Davis if you would, explain a little bit further the information you provided to Rob Nabors, who was detailed from the White House over to VA, that led to adverse employment actions being taken against you.

Mr. DAVIS. Yes. I contacted Mr. Nabors about 4 weeks ago. As the point of contact for the White House, I wanted him to be aware of what was going on in our office. A lot of attention has been placed on scheduling, but it's important to understand if you're not enrolled, you're not going to be placed on a schedule. I wanted him to know about shortcomings with the enrollment system, a system that many of you have talked about, we have spent millions of dollars on, and yet we're still back at square one with these VA systems.

I also reached out to him about a Medicare Part D marketing initiative by VA to encourage senior citizens who are veterans to drop their subsequent companion Medicare insurance and enroll in VA. That was problematic because, as you know, if you enroll in VA you can only use the pharmacy at VA. You have to use your VA doctor. Many of our most vulnerable veterans were not aware of that and could be confused and cancel their supplemental Medicare insurance and end up being stuck in the donut hole in the backlog.

I also contacted Mr. Nabors about the continued mismanagement of VA health programs managed by the HEC and the Chief Business Office under the direction of Mr. Philip Matkovsky and Lynne Harbin.

After sending that information to Mr. Nabors, I did not receive a response. I subsequently contacted the office of Deputy Chief of Staff Anita Breckenridge. I also did not receive a response until after receiving notification from Ms. Sherry Williams that she was contacting me on behalf of the Acting Secretary and Mr. Rob Nabors. It surprised me that Ms. Williams would do this because she is a former OIG official.

To this date no action has been taken to reprimand Ms. Williams for her behavior. This goes to the very heart of the question whether or not VA should be allowed to police itself and whether or not

an outside agency should be brought in to fully conduct an investigation into the actions taken at VA.

The last thing I will say is I did receive an email from the White House Office of White House Counsel directing me to contact the Office of Special Counsel. If that was the official position from the White House, there would have been no need for anyone to contact Ms. Williams about my complaint.

The CHAIRMAN. You also, in your testimony, you described the possible purging of over 10,000 veteran health records at the Health Eligibility Center, that there's a backlog of 600,000 pending benefit applications and 40,000 unprocessed applications discovered that span 3 years?

Mr. DAVIS. Absolutely. Currently we have over 600,000 pending applications. These are applications that have been applied for by a veteran, turned in to VA, and for whatever reason we could not take that application to a final determination. This backlog has reached again the number of 600,000. What we should have done, instead of hiring 40 people to address the Affordable Care Act in a belief that we're going to have this surge of people because of a buddy letter marketing campaign where the veteran was encouraged to pass on information about enrolling into VA health care to a fellow veteran, well, unfortunately, the information for the veteran to take the action was on the second page of the letter. Therefore we ended up getting 80,000 duplicate applications of which only about 1,650 were actually applications that we could actually do something with.

In terms of the 40,000, this was discovered in January of 2013, and this is important to the committee because I want to share something that was in a report that I forwarded to the committee from 2013. Increasing online application submissions versus paper and improving turnaround times for eligibility decisions has a positive direct impact on providing timely access to health care. Data reveals applications submitted in person are processed with higher urgency while online applications linger in a less visible queue.

To answer your question how could this happen, because these applications linger in a less visible queue. Even though the IT Department had paid licensing fees for over $40,000 for us to have a new system for managing the queue, a system referred to as BizFlow, that system was only put into play for implementation until after the 40,000 applications that were lingering in the queue, in some cases for nearly 3 years, was discovered. That is something that is shameful.

The CHAIRMAN. Thank you, Mr. Davis.

Members, I have one more question I'd like to ask Dr. Head.

Dr. Head, you talked about the retaliation against you, and I want to specifically talk about a Dr. Wang, who I read that the OIG concluded that Dr. Wang had, in fact, committed time card fraud. Is that correct?

Dr. HEAD. Yes. The official report was not released to the layperson. The information I received was that they had recommended immediate termination of her and this other individual. Through other chief of staff and counsel, they had said that they had found significant fraud, time card fraud.

The CHAIRMAN. And so she's been terminated?

Dr. HEAD. She has not been terminated. She has been maintained in a supervisory role.

The CHAIRMAN. Can you explain a little bit about how that has occurred?

Dr. HEAD. I have no idea how she was able to maintain her position.

The CHAIRMAN. But VA did not follow the Inspector General's recommendations?

Dr. HEAD. They elected not to follow the Inspector General's recommendation. She has been left in her Division Chief position. She was my supervisor. I filed a complaint, numerous complaints. They moved me from that office under her chain of command to the Chief of Staff, which in my opinion was an excellent opportunity. I rose in the ranks, became head of Legal and Quality Assurance, and have become I think an expert in system analysis and quality assurance, which I think will help the veteran even more, ironically, now from being retaliated against. That's just how I was brought up: Find a way.

The CHAIRMAN. Thank you, Doctor.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

As you all know, whistleblowers, you often risk your career in order to bring problems to light. What would you recommend that we do as far as to change the rules or laws government-wide to actually help protect the whistleblowers. And I'll start with Dr. Mathews and work down, if there's anything that we should do to strengthen the Whistleblower Protection Act.

Dr. HEAD. Yes. That's an excellent question. And one of the things that I experienced was that I was immediately removed from my position. So under the guise of an administrative investigation with a specific directive to not contact any of the psychiatrists that I was managing, and they cut off my access to the databases, some of which I'd set up myself to get accurate data. So one of the things could be that if there is this sort of an investigation, that the person continues rather than be detailed. And if the person has to be detailed, perhaps there should be a review by peers to see whether that's even warranted or not.

There seems to be no time limit to these kinds of detail. And this is the second time I've been detailed. Just recently I've been detailed again. So as Dr. Mitchell mentioned, these are not the jobs that we wanted to do, not that we would not do it. We would do it to the best of our abilities. So having that protection. Having the OSC have some sort of a time limit to review these complaints would be very beneficial. Having a process for, you know, like you rightly mentioned, if a supervisor is, indeed, found to have retailed, to have some very tangible consequences to that person would be very, very important.

Right now I think, at least in the St. Louis VA, they do not think that this is a serious issue. Like I said, like 2 weeks ago I was called into a meeting with the Chief of Staff where the chief of the outpatient psychiatry, the person I had worked with very closely to implement my changes was also called into that meeting. And in that meeting I was specifically told that the chain of command must be respected at all times, that if I had any issue or if Dr. Esses had any issue, that we should report it first to our supervisor

and then move up to the next level and the next level. So I called the—

Mr. MICHAUD. Could you finish up because I'm running out of time. We have got three others, so.

Dr. HEAD. Yes. So I think your recommendation for having very quick and serious consequences to retaliation would be very important.

Mr. MICHAUD. Thank you. Dr. Head.

Dr. HEAD. Yes. I think there needs to be greater repercussions for retaliation. We have laws referred to shield laws and sword laws. Sword laws meaning that if I retaliate against someone, there are Federal laws that say, look, retaliation is against the law, and they can warn the person don't retaliate. But they can continue to retaliate against the person, which ultimately will have a direct or indirect effect on the care of the veteran, endangering the veteran only because their caregiver or doctor or nurse is being retaliated against.

Shield law means that not only do you have a sword law, repercussions for retaliation, but you have a shield law where you can immediately take action and there can be immediate repercussions for any type of retaliation against the whistleblower. In other words, you tell the Chief of Staff, look, if this person gets retaliated against, pushed out of a job or anything, we're going to hold you accountable for this until we figure out what's going on here.

And we have a shield law that was enacted in the State of California, but that's something that should be considered by Congress. Ultimately you will address it one way or another because retaliation in the health place is different than in a factory, because if you retaliate against a physician or surgeon or nurse practitioner or nurse, you're going to have direct repercussions one way or another to the health and well-being of a veteran.

Mr. MICHAUD. Thank you. Dr. Mitchell.

Dr. MITCHELL. I'm not sure all of it needs to be legislated, but certainly the OIG needs to put in writing that providing limited patient information to support allegations in a complaint is not a violation of HIPAA. It isn't, but certainly there are employees charged all over the Nation for it.

In addition, sham peer reviews need to be part of the prohibited personnel actions. That's where they drum up a reason to examine a physician's cases. They have a predetermination that this physician is not properly functioning, even though there certainly is no problem with this level of functioning. And then they can permanently sabotage a physician's ability to get employed not only inside the VA, but in a private sector.

Whenever you're subjected to a peer review you have to report being a subject of a peer review for the rest of your professional life, on every job application, on every license renewal. Sham peer reviews are done specifically to sabotage the credibility of a physician. Physicians truly face losing their livelihood, their ability to be employed again as a physician. You need whistleblowers that are physicians, people that are trained to identify the high risk problems.

Mr. MICHAUD. Mr. Davis.

Mr. DAVIS. Yes, thank you. I don't know if a new law would really change anything, honestly, at VA if you don't have accountability. I think there are some structural changes that need to take place, one being a centralized human resource office that actually has operational authority.

Currently, when I went through my situation of retaliation, I spoke with a representative from the VA HR office. They told me they're only a policy body, that they could contact the HR office where I work and maybe make some recommendations and see what they could negotiate. That's problematic, because in VA, unlike a corporation or a normal healthcare system, every division or the hospital itself has its own HR department which becomes the secret police force for the managers who harass employees. And that's problematic, and that's what needs to change. So I think an operational change for a centralized human resource office would also help.

But also I think you need to start making bad managers pay their own legal fees. Currently, managers who engage in harassment have no fear because the bill is going to be passed on to the taxpayer. And even if they lose the case or they're found guilty of wrongdoing, well, the bill just goes on to the taxpayer. Currently, we have managers in our office that have several different complaints for harassment. It's not a big deal to them. Regional counsel will take care of it. The Office of General Counsel will take care of it. So I think that's the issue that really would change people's behavior, if you hit them in their pocket.

The CHAIRMAN. Mr. Lamborn, you're recognized for 5 minutes.

Mr. LAMBORN. Thank you, Mr. Chairman, for having this hearing.

And I want to thank all of you for being here. You're showing a lot of bravery and courage. You're putting it all out on the line to do this, and I know that you're doing it for our veterans.

Dr. Mitchell, I'd like to ask you, you've been at the Phoenix VA for 16 years. Do you believe that the lack of response to safety issues that you've brought up over the years have threatened the health and even the life of veterans in Phoenix.

Dr. MITCHELL. Yes. Anything that impairs the efficiency or the delivery of care threatens the lives of patients. Certainly in the ER I can recall at least three specific deaths and several more I believe actually occurred in the ER. As a resident I also trained through the Phoenix VA. There were at least two patients I know that died because they were delayed in getting their cardiac cath because the VA only did cardiac catheterizations Monday through Friday, not on weekends. These veterans had to wait because there wasn't time to get them done on Friday, so they died on Sunday.

When I was a nurse there, there were tremendous problems with patient care, and there weren't sufficient nurses to turn patients the adequate number of times. We had patients developing huge bed sores. I can remember JCAHO certification inspections that to this day still haunt me because administration would authorize overtime for charting, because a JCAHO administrator would look at charting, but would not authorize overtime for nursing staff to turn patients because there wasn't enough staff to do it or to feed

patients. We used to volunteer our time quite a bit because we couldn't leave the team short staffed.

Mr. LAMBORN. Doctor, did these problems catch the hospital and the administrators by surprise or had they been warned that there were pending problems if something didn't change?

Dr. MITCHELL. I am aware of problems throughout the facility without necessarily having access to upper administration. I know that people communicate these concerns as best they can. What happens is any concern you bring up you have to present to your supervisor in a politically correct manner, because if you don't you will be retaliated against, either you'll be harassed at the moment you're giving the information, your proficiencies will drop, something bad will occur. It's best that management not know your name, because if they do it makes you an automatic target. And I'm sorry, that's not to say that all supervisors are that way. There are some incredibly ethical supervisors at the facility where I work.

Mr. LAMBORN. Okay, good. That's good to hear. The interim OIG report which brought out some of the issues that we're seeing even better as a result you believe didn't go far enough, if I understand your testimony correctly. Do you think that there were flaws with the methodology and that it could have even been more revealing of problems out there?

Dr. MITCHELL. There's a saying that has to do with lies, damn lies, and statistics. And what they did was they took out a segment of patients and said, well, this is the average wait time. The NEAR list that they were looking at was divided by clinics. Some of the clinics had relatively short waiting time. The NEAR list ran from I believe January of 2013 to April 24 of 2014.

Some clinics had very short waiting times. The downtown Phoenix clinics were all aggregated or an aggregate of some, and the waiting time started at 477. They didn't hit down to the 110s, 120s until page 8 or page 9. Because some of the wait times were zero or 1 day or 2 days, because they extended up until April 24, I have no idea which patients they picked. It would have been certainly more accurate to say at the Phoenix VA clinics we had this many patients waiting zero to 30 days, this many from 31 to 45.

Mr. LAMBORN. So as a result, and we are getting the real detail here, you don't think that the report revealed nearly as much of the problems as it could have?

Dr. MITCHELL. No. I told them about the mental health waiting delays, the huge problems with that. Other people told them that, the issues. I told them about the patient safety issues. It certainly didn't go into that.

Mr. LAMBORN. Okay. Thank you.

Once again I want to thank you all for your service to our veterans and for being here today.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you.

Mr. Takano, you are recognized for 5 minutes.

Mr. TAKANO. Thank you, Mr. Chairman.

Dr. Mathews, are you familiar with the Federal classification of employees, whether it is SES or Title 38 employees? Are you aware of that system?

Dr. HEAD. Yes.

Mr. TAKANO. In your capacity as chief of psychiatry, was that a Title 38 position; do you know?

Dr. HEAD. Yes. Title 38 position.

Mr. TAKANO. Okay. Dr. Head, in your position where you formally were, was that a Title 38 position or something below a Title 38?

Dr. HEAD. Title 38. I am still employed by the——

Mr. TAKANO. You are still employed, I understand.

Dr. HEAD. Yes.

Mr. TAKANO. Okay. And Dr. Mitchell?

Dr. MITCHELL. Yes, I am a Title 38 employee, and I have been employed as a physician throughout my VA career there.

Mr. TAKANO. Okay.

And Mr. Davis?

Mr. DAVIS. No, I am just a General Service employee.

Mr. TAKANO. General service employee.

So one of the things I am grappling with is the proposal for us to make it easier to fire VA employees guilty of wrongdoing, so a more at-will sort of basis, and that would apply to the Senior Executive Service. And typically whistleblowers come from the lower ranks of employment, but there is a debate about whether or not we should extend this sort of standard to Title 38 employees. And so in my mind, I am going through this contradiction of, well, there is a sense among some Members that we want to make it easier to fire people at certain levels of service, but that might seem to run against the idea that we need to also protect people who speak up.

Dr. Mathews, do you have any thoughts on this? We have a whistleblower protection, but, I mean, how do you feel about making it easier for us to fire Title 38 employees?

Dr. HEAD. Well, I think, you know, when veterans' life and health is at issue here, I think that, you know, you should be able to be fired. Any person in direct patient care right now enjoys almost a lifetime tenure where they are completely protected from their actions, the consequences of their actions, and I think that is not good for providing a safe work environment for the veterans, or safe health environment for the veterans, or work environment for the physicians and other people who come forward.

I do not think that the Chief of Staff or the Chief of Mental Health, who just threatened me 2 weeks ago, has any concern about their position being threatened in any manner. So I think that kind of protection should end.

At the same time, I also would want us to consider that a workplace is only as good as the employees there, and I'm hoping that we take a look at what the salary structure is, especially for some hard-to-fill positions, so that, you know, we can have less protection with——

Mr. TAKANO. Dr. Mathews, excuse me, but wouldn't that ability to have fired you so absolutely have eliminated your ability to even voice any dissent or act as a whistleblower?

Dr. HEAD. Well, that already exists. I mean, they already professionally assassinated me in the sense that, you know, I'm no longer the Chief of Psychiatry. They've already spread this, you know, the fact that I am no longer the Chief of Psychiatry. In fact, the way

I found out that there was this—you know, this administrative investigation stuff going on is when one of the psychiatrists I recruited called me concerned that, you know, are you fired? I mean, I hear that you're fired. So professionally—and it's a bad statement on the VA that, you know, me having trouble with the VA is——

Mr. TAKANO. But would you have been worse off having your voice completely eliminated by you being summarily fired because they had the ability to do so? You at least are able to be here and voice your concerns. And actually, I mean, it's far from where we need to be in order to have feedback from people at the mid level and lower levels to be able to say what is wrong.

That is our interest, right, I think, in our national interest, to be able to have lower-level employees be able to speak up without fear of being retaliated, but is whistleblower protection enough? Do we need to have some sense of due process, which some of the Members would like to see eliminated so it's easier to fire people? I see a tension here. I mean, I think you might even recognize. I, too, would like to be able to fire people, not have them have complete tenure and they feel insulated.

Dr. HEAD. Right.

Mr. TAKANO. But I don't know how we solve this.

Dr. HEAD. Well, you know, I think one way that I can suggest is to put ourselves or our loved one in the veteran position. Would I want to obtain care, or would I want my son to obtain care, at a system where poorly performing nurses or physicians cannot be fired? And I would not want to go to that hospital. So I think, I mean, that would help perhaps resolve this tension about who are we protecting? Are we protecting the veterans, or are we protecting the VA employees?

Mr. TAKANO. I understand.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you very much.

And also, the legislation that we have passed in the House does not reach down to this level of a SES or Title 38 employee, only senior level, the top 450.

Mr. Bilirakis, you're recognized for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it. Thanks for holding this hearing.

And I want to thank you, the people that are testifying tonight, for putting the veteran first. Thank you so much for your courage. I really appreciate it.

Dr. Head, I know I don't have a lot of time, you mentioned in your testimony that this potentially could be—the VA system, VHA, could be the best healthcare system in the world. How do we get there?

Dr. HEAD. I believe with leadership. You know, there are certain people in leadership that have been there for 18, 20 years, and if they're a great leader, it's fabulous; but if they're not, it's very disruptive to the system.

We need to find ways to bring in leadership on a continuing basis. Maybe term—I don't know if this is the answer—maybe term limits. And if you're a good leader, you're identified as a good leader, and perhaps you could be part of the team that brings on new leadership and show them the right direction. And if you're not

such a good leader, maybe you should be integrated in another part of the Federal Government or retire.

But leadership is clearly the key. Our surgical team at the West L.A. VA could be matched against any surgical team in the country, possibly in the world. My wife, much smarter than I am, is an interventional electro physiologist, cardiologist at the VA. She could work anywhere in the country. Somehow she agreed to marry me and also dedicated her life to serving veterans. She loves her job. She obsesses over it. She's always worried about trying to save another veteran. I commend that. And there's lots of people like that within our system.

We need leadership. The leadership will take the VA to that next level. I think it's not resources. We all care about the veterans. And you're very giving. And we'll do anything to serve our veterans. And it's not resources. We'll do anything it takes to make this situation right and to serve the veterans. And I have no doubt that if the right leadership is brought to bear on this problem, we can solve this problem.

Mr. BILIRAKIS. Thank you.

My next question, and this is for the entire panel: In the previous fiscal years, all Senior Executives Service employees, all received a fully successful performance. Last year, in particular, they received a fully successful performance, which totaled to $2.8 million in performance awards. Yes or no, and we'll start with Dr. Mathews—yes or no, do you believe that this is an accurate assessment and that all eligible senior employees performed at a fully successful capacity and higher?

Dr. HEAD. No.

Mr. BILIRAKIS. No. Okay.

How about Dr. Head?

Dr. HEAD. No.

Mr. BILIRAKIS. Mr. Davis?

Mr. DAVIS. Based on what we now know in the public record, absolutely not.

Mr. BILIRAKIS. Dr. Mitchell?

Dr. MITCHELL. No.

Mr. BILIRAKIS. Thank you.

Next question is for Dr. Mathews: Through your own investigative work during your time at the St. Louis VA, you identified that on average—you spoke to this in your testimony—on average, psychiatrists were seeing six veterans per day, which accounted for 3.5 hours in an 8-hour workday. When you contacted other psychiatry chiefs regarding actual time spent in direct patient care by psychiatrists seeing veterans, do you know if they had been tracking this information prior to your inquiry?

Dr. HEAD. No, I do not know if they were tracking it. I know that our VA does not track it, and I know that many other VAs do not track it, because a lot of the other chiefs wanted to know the answers as well. So I got a lot of emails from other chiefs saying, you know, why don't you forward the responses to me as well? And just recently there was another new Chief of Psychiatry who had the exact same question that was, you know, sent out to everybody saying, you know, what is a reasonable expectation? What number should be reasonable?

Mr. BILIRAKIS. Thank you.

Next question, again, for Dr. Mathews: Your findings also discovered that 60 percent of veterans were dropping out of mental health care after one or two visits. And I have town meetings, and I have veterans advisory councils, and they tell me the same thing. Do you believe it was directly connected to the experience they had while seeking treatment with the VA? Is it the type of treatment? Should there be alternatives to that treatment? If you could——

Dr. HEAD. Sure. You know, my goal was to make the VA mental health clinic a very welcoming place with very easy access to care. The majority of the veteran complaints that I reviewed had to do with long wait times, not being able to come to seek their care, and, you know, that really demoralized them from obtaining care.

Some of the young veterans that I saw in my new capacity—well, the previous capacity as the compensation and pension evaluator, I came across some really horrendous barriers to care for veterans who had tremendous amount of combat exposure. They were in some of the specialized forces.

And just one instance I will mention here——

Mr. BILIRAKIS. Please do.

Dr. HEAD [continuing]. This veteran was doing so poorly that his roommate, who was also a veteran, had both taken off a day of work so that he can take this veteran and get him care. So they come to the VA, and it takes 3 or 4 hours to find out whether this person is even eligible for care or not, and then they determine that, yes, this person is actually eligible for care.

So this veteran then comes to the PTSD clinic and is not seen by a healthcare provider, is told that we will contact you next week after a meeting to determine what we can—what we are going to do for it. Now, I was doing a compensation and pension evaluation, so I had access to the records, and I was looking at whether there's a record of this veteran actually going to the clinic or not, and I did not find any record. But there is a subsequent notation saying—a form letter that was sent to this veteran that stated that we learned that you were interested in obtaining care at our facility; please call these numbers to schedule an appointment.

So this is for a veteran who has served our country and sacrificed a lot, who even the military recognized had PTSD, had taken a day off of his low-paying job to obtain care, and then there was no record of this person being at the VA, and the contact was not made. So when I evaluated him, I asked this person that, you know, would you consider coming to the VA to obtain care, and this veteran was very clear in saying, no, I am not going to obtain care here. I was not treated with respect. And, you know, he didn't want to come to get care there.

So that's one really bad example that I can say about how the access to care and the whole attitude of it not being a welcoming place, of erecting barriers, you know, that really prevents people from coming back. And there's a lot of such complaints that I heard in my capacity as the Chief.

So yes, the answer is yes. You know, how we are interfacing with the veteran, what kind of access we are providing, and what kind of care and environment we are providing, I think, is critical in maintaining patients and care.

Mr. BILIRAKIS. Thank you very much. I appreciate it.

Thank you all for your testimony.

The CHAIRMAN. Thank you.

Ms. Brownley, you're recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman, and thank you for holding this hearing, and thank you to all of you for being here. Your testimony is extremely important, and we appreciate it very, very much, and I believe that all of you, by virtue of being here and having gone through what you have gone through, you have also, as our veterans, served our country honorably. So thank you for that service.

I just wanted to ask Dr. Mitchell and Mr. Davis, because both of you went through a—well, Dr. Mitchell, you went through a formalized process, a confidential process with the OIG, and somehow that information leaked out, and it was not confidential. And, Mr. Davis, you reached out to the White House, and obviously there were—based on your testimony there were leaks as well. So I was wondering if the two of you could just comment on do you know how those leaks occurred? Were you promised confidentiality?

Dr. MITCHELL. Yes. The Senator McCain's office submitted the request—or my complaint with two requests, one, that there be an outside investigative team because the local OIG had a long history of not doing very good investigations, and the second one was that my name be kept confidential. I don't know who leaked my name; I just know that it was leaked. And I don't even know if there's any consequence to whomever leaked my name.

The second thing is I don't even know if the OIG actually investigated. What happened was there's no official report, although certainly the Web site—the OIG has complete discretion as to which reports it puts on the Web site. Anecdotally I have been told that those that are unfavorable to SES service do not go on there. Someone has since forwarded me a complaint that is certainly unfavorable to SES service, and it can't be found on the Web site. I have no idea what occurred, and I can't even get a report of it.

Ms. BROWNLEY. Have you tried to find out, though?

Dr. MITCHELL. I had Senator McCain's office checking, and they're stonewalling them.

Ms. BROWNLEY. Thank you.

And Mr. Davis.

Mr. DAVIS. I can tell you that as late as about 4:30 p.m. this evening, I was informed by my union president that the Acting Chief Business Officer Stephanie Mardon sent a correspondence saying that Ms. Williams, the person who said she was responding on what behalf of Secretary Gibson and Mr. Nabors, was not officially authorized to speak on their behalf.

What she didn't provide, which would probably be more important, is who told her in the first place. And I think that is the problem with VA: a complete lack of accountability. And when people know that they can engage in behavior without consequences, something has got to change.

Ms. BROWNLEY. Thank you.

Dr. Head, I represent Ventura County in California, so my veterans use your facility in West Los Angeles. And so I am wondering, after being here this evening with us, what it's going to be

like for you when you return back to West L.A.? What will the environment be?

Dr. HEAD. I'm not sure. I do fear retaliation, but I also know this was the right thing to do. And more importantly, I think many veterans that I care for support me.

Ms. BROWNLEY. And do you believe by virtue of what you have been through and now being here, do you think that that has—and everything that has happened, and what we have learned about what is going on in the VA across the country, I mean, do you feel a difference when you go back to West Los Angeles than you did a few months ago?

Dr. HEAD. Well, I think more importantly I've enlightened, I believe, Congress, and they have an opportunity to look very factual. All I ask is that you look at the facts and unveil the facts, and I think that in itself will be helpful.

And as far as going back to my job, I could afford not to work, but I want to work, and I want to serve the veterans. And when I first came, Dr. Mitchell and I were chatting, and we both want to retire within the VA Administration.

Ms. BROWNLEY. Yeah. I think I'm just trying to drill down a little bit to see if there's been any shift or change over the course of the last month or two in the culture, because you feel it every single day, and, you know, changing culture is really a hard thing to do. But I'm just curious to know if there's been—you know, do you feel a shift?

Dr. HEAD. I think there's been awareness. They are very much aware that I was coming here tonight, and I think they're very much aware that I will stand up for myself and for the veterans, that I will not cower down.

I'm human, I have my frailties, and this is wearing on me. I wish I could just go to work and dedicate all my energy to caring for veterans and to make processes that will improve the care of veterans, but instead, the reality is I do worry about retaliation on a daily basis. I'm always looking over my shoulder. I'm always wondering about, you know, peer reviews. Fortunately, I've been head of a certain area of peer review, so I've been immune to some of those retaliatory efforts.

I am worried, and I'm tired. If you could do one thing for me tonight, you would relieve the obstructions of this retaliation and allow me to serve the veterans and be able to work without the fear of retaliation. That would be a great gift.

Ms. BROWNLEY. Thank you, Dr. Head.

And again, thank you to all of you, and my time is up, and I yield back.

The CHAIRMAN. Thank you.

Dr. Roe, you are recognized for 5 minutes.

Mr. ROE. I thank you, Mr. Chairman.

Dr. Mathews, I was a young doctor once, and I remember returning from Southeast Asia, and I was full of vim and vigor, and I was stationed at Fort Eustis, Virginia, and there was 2,000 women that needed Pap smears. I was going to solve that problem. When I left Fort Eustis, Virginia, there were 2,000 women on the Pap smear list. I ran into inertia, which is what I think you ran into.

And I admire what you did because you touched on two very important things. You all have hit the nail on the head. It's the backlog, which we can easily take care of. We can do that. Number two, changing the culture of the VA is going to be much more difficult, and that's much more critical downstream years from now.

But what you did when you got to the VA in psychiatry was you recognized a problem. You saw long wait times for patients, and you wanted to make sure those patients in need got there. And I have seen those patients in my office.

Two, you said how much work are we actually doing? And when you evaluated it, you found out that your colleagues were seeing basically six patients a day. There's no private practice in the world doing anything that can stay afloat seeing six patients a day.

So you wanted to increase productivity, shorten the wait times. And what I found astonishing was that 60 percent of our veterans who sought out care—and these are folks have PTSD that desperately need this care, and we know there is a shortage of your kind of specialty in the VA and in the country, quite frankly—wouldn't come back. I found that absolutely amazing to me that they found the environment so inhospitable to them that they refused to come back.

And then very simply, how we're all being evaluated with accountable care organizations and so forth is were you satisfied with your visit? A very fair question. And you hit the nail right on the head a minute ago when you said, what if you were the veteran? Would you want to be in a place where less-qualified people or people who didn't seem to have your best interests at heart, would you want to be them?

I want to ask all of you, Dr. Head and Dr. Mitchell, too, just very briefly, how does retaliation within the VA affect patient care? And I think we all know that, because if you're retaliated against, you go back to the six patients a day, that means 60 percent of those veterans that need care are not getting it. Am I right?

Dr. HEAD. That's unfortunately the case. And I can tell you that being in compensation and pension evaluation, I know of at least one veteran who committed suicide while waiting for, you know, the call-back to get care. So, you know, unfortunately it went back to where it was, and we really don't have a real-time veteran satisfaction with care metric.

And I think that's very important, because we do not really know, other than these surveys which are incomplete and which are administered not correctly. You know, mostly the clinic itself hands out these surveys to the veterans to fill out, and then they collect it as well. So although you tell them it's confidential, I don't think anyone would really believe that.

Mr. ROE. Yeah, I think you could take what you did and go across primary care, specialty care, anything, and find out is it a staffing need? Do we need more people to work, or do we need to be more efficient at work while we're there?

I want to ask Mr. Davis a question, and it dawned on me just a minute ago, what happened to the 40,000 veterans that were queued up? What happened to them?

Mr. DAVIS. Well, the 40,000 veterans that were discovered, 40,000 applications, they were eventually processed. But I think

here lies the problem of sort of the callous and carelessness in VA management, and that's why I go back to my point of make them pay for it.

The problems with the queue, as it's referred to, could have been addressed. Again, VA was paying for licensing and maintenance fees for them to institute a new workflow management system that could have resolved that issue. It wasn't resolved or addressed until after the 40,000.

Now, what's interesting is—and I'll give you an example of the sort of lackadaisical attitude by VA management. In the report that I read from earlier, in 2013, it talks about the backlog. It talks about the slow processing of online applications. You're a physician. Could anyone imagine an application for health care that you can write in your house, drive to a VA medical facility, wait in line, turn it in to someone at the counter, wait for them to process it is actually faster in 2014 than the online process? If this was a private corporation, we would be run out of town.

Now, let's put that into context. I have submitted to the committee a document, a fact-finding report, which dealt with the marketing contract, that dealt with waste and mismanagement, and it addresses the issue at our office that the contract was so poorly mismanaged that the $5 million contract would not withstand scrutiny if it was subject to a third-party audit.

I ask you to look at this in the context of the enrollment system, look at it in the context of the workflow management contract, about $2 million. It's the same sort of reckless attitude. They don't assume responsibility for their actions when it comes to retaliation, and they don't assume responsibility for their actions when it comes to wasting the resources given to them to provide services to veterans.

Mr. ROE. Mr. Davis, just one other thing, and it's a statement, not an answer. But in our briefing today, it said—and officially the St. Louis VA Medical Center is reporting to VA central office that its productivity was along the highest in the Nation. When that sort of thing happens, how in the world can we believe anything that's in front of this committee? I get asked at home, why do you know about this? And I say, well, we get this kind of information. How would we know about it when the people giving us information are not giving us factual information?

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you very much.

Mrs. Kirkpatrick, you're recognized for 5 minutes.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

I'd like to start by thanking our whistleblowers for having the courage to come forward when you witnessed wrongdoing. I would particularly like to recognize Dr. Katherine Mitchell from the Phoenix VA. I asked you to come and testify before our committee. I know that you've risked your career to report wrongdoing and suffered repeated retaliation from administrators who refuse to do the right thing, so thank you.

By bravely stepping forward, Dr. Mitchell and Dr. Foote made Congress, the IG and the VA aware of the problems in Phoenix which led to the discovery of systemic patient wait time data manipulation at VA facilities across the country. Unfortunately, with-

out whistleblowers we were unable to identify many of the problems in the VA. Because of whistleblowers, we can now work to fix them.

It is unacceptable and reprehensible that almost half of the Office of Special Counsel's whistleblower retaliation cases involve the VA. The bullying of patients and VA employees that report wrongdoing must stop now. I sent a letter to Acting Secretary Gibson last month asking him to remind all VA employees of their rights at whistleblowers; however, it is not enough that employees are informed of their rights. The VA must still develop a culture of zero tolerance for whistleblower retaliation at all levels of its organization.

Employees should not be afraid of losing their jobs or ruining their careers for speaking up when something is wrong. Patients should not be afraid that they will be denied care because they think something is wrong. The VA must stop using the harmless error defense to downplay wrongdoing. This finding by the VA Office of the Medical Inspector in most cases was baseless and an excuse for administrators to do nothing while patients were put at risk.

This is why I'm introducing a bill this week to give further protections to VA whistleblowers. Employees and patients should be able to report wrongdoing directly to the Office of the VA Secretary so they do not have to face retaliation from the same administrators that refuse to act. The office will investigate complaints of whistleblower retaliation and ensure that whistleblowers' rights are protected.

While all VA employees should work to serve veterans, the sad reality is that the VA has a corrosive culture and a history of retaliating against those who speak to break the code of silence. Until the VA is able to instill transparency throughout its ranks and develop a culture focused on caring for veterans, I believe additional protections for VA whistleblowers are necessary.

My question is for all of our witnesses: If you could name one thing that the VA could do immediately to change its culture of silencing whistleblowers, what would it be? And let's start with you, Dr. Mathews.

Dr. HEAD. Well, if I had one wish, that would be that data integrity is there. And the VA has demonstrated over and over again that they will make up numbers, they will come up with blatant lies. Like Dr. Mitchell said, and I will paraphrase the great person from Missouri, Mark Twain, that there are lies, damned lies, and VA statistics that go beyond lies.

So that would be my one wish would be to have meaningful metrics that are transparent and accurate and are vouched for by another organization, perhaps a major university that have a higher degree of integrity, and people who are found cooking these numbers are punished, because it has real-life consequences for veterans. These are not just, you know, some games that they are playing. People's lives are at risk here.

Mrs. KIRKPATRICK. Thank you, Doctor. Not to cut you off, but I want to hear from the others. I'm starting to run out of my time. I have about 45 seconds here.

Dr. HEAD. I believe accountability. When people or supervisors have knowingly done something wrong, and they have been shown they have done something wrong, but they're allowed to maintain their position, sometimes even get raises and bonuses, that should be unacceptable. You're sending a signal throughout the entire VA that——

Mrs. KIRKPATRICK. Thank you. I'm sorry, I'm just going to go quickly to Dr. Mitchell and then Mr. Davis.

Dr. MITCHELL. I think that most whistleblowers want to make sure that—they are willing to put their careers on the line, but they want to make sure that if there is retaliation, it will be investigated immediately. Right now they sent out the memo that said all the places you could go if you felt you were being retaliated against. Those haven't worked in the 16 years I've been there. No one that I know of thinks that they'll work, and they're waiting to see what will happen.

Mrs. KIRKPATRICK. Thank you.

Mr. Davis.

Mr. DAVIS. I think the body that's going to be responsible for enforcing whistleblower protection at VA cannot be a part of VA. I can tell you that whistleblowers who shared information with me to take to the committee are scared to cooperate with the OIG.

Mrs. KIRKPATRICK. Thank you, all. I've run out of my time, but thank you all very much.

And thank you, Mr. Chairman, for the extra time.

The CHAIRMAN. Thank you, Mrs. Kirkpatrick.

Mr. Flores, you're recognized for 5 minutes.

Mr. FLORES. Thank you, Mr. Chairman.

I thank each of you for your service to our veterans, also for your courage in joining us here tonight to share your stories.

Dr. Mitchell, as you know, the VA has had several internal investigations now. We've had reviews by the medical inspector. We've had OIG inspections or reviews. We've actually had a couple of high-profile resignations. And so in response to that, the VA has begun to make some changes and take some actions to try to deal with the news that's come out.

My question is this: Based on what you've seen so far, will any of the changes in activities that the VA's been involved in the last 3 or 4 weeks really make a measurable difference in the care for our veterans?

Dr. MITCHELL. No. Right now what's happening is that although they've checked into—looked into the appointment scheduling, nothing has changed for me. The chain of command that refused to investigate nursing retaliation is still in place. The chain of command that authorized a written counseling for violating a policy and then said they don't have to tell me what policy I violated is still in place. The chain of command that interpreted the 24/7 Federal contract to mean that I could be forced to work unlimited scheduled shifts for 2 years without any compensation is still intact.

You've only addressed the scheduling issue. You certainly haven't addressed what's happening when you bring all those vets in, and you've already got your physicians overloaded.

Mr. FLORES. Okay. That's the answer I was afraid that I was going to get.

Dr. Head, I think you passed over something pretty quickly in your testimony. You said that your pay was stopped for a while. Did you say that?

Dr. HEAD. Yes.

Mr. FLORES. Were you ever told why it was stopped? Was it blamed on administrative error or what?

Dr. HEAD. I was accused of time card fraud, and they said they weren't going to pay me. And when I obtained an attorney and showed proof of my presence, they paid me. But it took a number of months to do that, and, you know, I interpreted that as clear retaliation. It was a very painful time when that occurred, and they really gave me no clear explanation.

Mr. FLORES. That's truly amazing that the Federal Government would do something like that.

Mr. Michaud asked a question regarding legislative fixes to some of the things we're talking about. Let me ask you this: I mean, is there any legislation that we could do to fix the culture at the VA? I mean, I think what each of you have said clearly in your testimony, we have a real cultural issue, a sick culture at the VA. What can we do legislatively to fix that, if anything?

Dr. HEAD. I'll be very brief. You know, I think there has to be some fear of accountability. Currently evidently certain individuals feel they can act with impunity; that either the system is too slow to respond, or maybe it never responds. But they fear they can engage in these activities and know that they have government attorneys to represent them on the taxpayer's dollar to protect them in these legal fights. And sometimes they know they're absolutely wrong, and they have a protracted battle on purpose because they know most individuals can't withstand that type of punishment.

Mr. FLORES. I see.

And, Mr. Davis, anything you could add to that?

Mr. DAVIS. I would echo what I said earlier. You have to spread the accountability. It's one thing to have a VA manager go through initial lawsuit or some sort of just claim of retaliation and be represented by an attorney, but when you see a pattern behaving—just as when we look at people's time cards, if you see people constantly taking Friday off, you know something is probably wrong, if you see the same VA manager constantly being represented by the General Counsel's Office, then at some point you need to less that coverage.

Think about it like car insurance. If I keep banging my car into other cars, I'm going to get dropped off the policy. So if the VA official continues to put the agency at risk of litigation and liability, then the coverage should lapse as well in that situation.

Mr. FLORES. Dr. Mitchell?

Dr. MITCHELL. I would agree with the others on the panel in the interest of time.

Mr. FLORES. And, Dr. Mathews, you can go until the light turns red.

Dr. HEAD. Okay. I'll be more mindful.

So if I had two wishes, the first would be that the data integrity should be there, because once the data is transparent and accurate,

I think, you know, our lawmakers can act on it, the veterans service organizations can act on it, the newspapers can report on it. Now, if they just cook up data, there is no way to even find out that there is a problem, so that would be number one. And the second thing—and, at least for a short while, to take away that responsibility away from the VA, of managing their old data. And the second is, I agree with everybody else about accountability and not having lifetime tenured positions.

Mr. FLORES. Thank you, Dr. Mathews.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you.

Dr. Ruiz, you are recognized for 5 minutes.

Dr. RUIZ. Thank you, Mr. Chairman.

Thank you all for being here.

I'm an emergency medicine physician, and oftentimes we're put in a position where we are the last stop for our patients, the gatekeepers, and also in the front lines in taking care of our patients. And I understand that we have to sometimes fight the system very hard in order to do what's right for our patients, because if not us, then who?

And I appreciate all of your efforts in advocating for your patients despite the consequences and the risks that you put on yourselves regardless of your specialty or of your responsibilities in the hospital, and that's admirable, and that's what I refer to as a high-quality, veteran-centered culture of responsibility and accountability in our VA system that we need to transform into. We're not there yet, and we need to make sure that we apply the mechanisms, the processes and the evaluations within the system that will lead to a veteran-centered institution.

Now, having said that, in the private sector and in our training as physicians, there's a form of ceremony that we do that ensures that we address these atrocities, and that is the M&M rounds, morbidity and mortality rounds. Do you have those, Dr. Head and Dr. Mitchell?

Dr. MITCHELL. Not for the emergency room. I know that they exist in surgery service.

Dr. RUIZ. Do you have one, Dr. Head?

Dr. HEAD. Yes, we do. It's more traditionally in surgery, but we have equivalents for internal medicine, also for emergency.

Dr. RUIZ. I think all specialties should have them. Emergency medicine practices throughout the country also have them where they review things that went wrong, mortalities, people that have died, and what were the causes of those. Do you have the COO of the hospital or Administrator sitting in to listen in to determine if there was any lapses of any systematic failures that led to those problems? Dr. Head?

Dr. HEAD. Traditionally there's several layers. We have our risk management committee, then it's presented to risk management. I often will hear things either through the tort process or a week or two after it's been presented, and then egregious activities presented by our Chief of Staff directly to the COO.

Dr. RUIZ. Well, there should definitely be metrics based on those morbidity and mortality results and classifications to determine if it was a staffing issue, a medical error, any lack of processes or fol-

lowing in integrity and practice, or lack of judgment, et cetera. And that will give information as to what needs to happen, and that information should be directly linked to the COO's and the Administrator's ability to make those changes that are necessary.

The other way to ensure a systemic and a transparent, open way to evaluate certain practices so that we don't have to rely on whistleblowers are through chart reviews and spontaneous or random audits. Do any of that exist in your practices?

Dr. MITCHELL. I was the person that would look at the issues that would come up, because the physicians would give me all their cases. I asked them to do that so that I would be the only one that would be retaliated against by the nursing staff.

I do know there is a process of looking at suicides in our facility, but the chain of command over that area refuses to release that information. That was not even available to the suicide prevention team members when I asked them.

Dr. HEAD. And the M&M process is only as strong as the people who self-report those issues. If there is a complication, it's not reported, it can become invisible.

And the other thing, too, is another strong part of our component, of our institution's root cause analysis, but that's only as strong as the ability to actually report an incident. If an incident is not reported, then it can go invisible. And usually I will catch it later, several years down the road when it's coming to the tail end of the tort process. It's too late at that point.

Dr. RUIZ. Yeah. I agree, and I think that mortality is very evident. When somebody dies, that should be investigated and determined if there was any wrong during that care for that veteran. I believe that part of the solution, and I'm very encouraged on Ms. Kirkpatrick's efforts and advocacy with the Phoenix VA, and I appreciate her leadership, and I believe that the idea of taking the responsibility away from those that will have to do self-evaluations, from those supervisors, and placing it in another location that has more of the advocacy role is a very good idea.

With that, I yield back my time.

The CHAIRMAN. Thank you very much, Doctor.

Mr. Runyan, you're recognized for 5 minutes.

Mr. RUNYAN. Thank you, Chairman.

And thank you, all, for, again, your courage to come out and stand up for our veterans.

Mr. Davis, I want to just put this out there because I know Dr. Ruiz just talked about this, and Ms. Kirkpatrick had ran out of time, but, again, a statement you made earlier: Can the VA police itself, and if not, who?

Mr. DAVIS. Thank you. I don't think VA can police itself. It's kind of like a scholarly journal; you don't peer-review yourself. I would look at maybe an organization like the Government Accountability Office maybe finally setting up some sort of oversight panel of healthcare professionals.

One of the things I will tell you that VA employees talk about is during the financial crisis there was talk about bringing people like Elizabeth Warren. During the talk about national security issues, they talked about bringing back Dr. Gates. When we had the crisis in VA, we were sent the Deputy Chief of Staff, and that

is no disrespect to Mr. Nabors, but where's the medical leader that's going to come rescue health issues at the Nation's largest health organization? And I think that's the issue. It goes to the issue of how people look at VA.

One of the reasons why I reached out to the White House was because I was trying to find the person who could answer questions and resolve the issue. We have almost a czar for almost everything you could imagine in this town, but not one for veterans, and I think that's the issue. There has to be an outside source to say, Mr. Chairman, Members of Congress, Mr. Speaker, Mr. President, I have noticed this information; this information came to me; it's not going to work.

In terms of the context of giving the Secretary the right to fire people, in November 2013, a memo was released by the Assistant Secretary for Human Resources stating that employees were not to go to the Secretary's office about complaints because it obstructs the final decision of disputes, but he still will accept confidential emails. Well, if that's the approach they take, even if we change the law, we still would not get the information to the right people to hold the 400-and-something-odd people accountable. There has to be some change in the law to allow outside institutions to become the policing organization over VA. It's simply not going to come from within.

Mr. RUNYAN. Which kind of leads to my next question, and I'll ask Mr. Davis first, and if there's any time left, I'll ask Dr. Mathews to follow up. Because Dr. Mathews said in one of his statements that he doesn't necessarily know that it gets above the St. Louis regional into maybe the central office. Can you shed some light on that?

Mr. DAVIS. I can shed light on that. I will tell you the only reason why my case got to where it was, because I didn't go through the elongated grievance process, because that's a way of trapping the employee and constantly filing complaints, filing complaints, appeal process after appeal process.

What I decided to do was to go to the person at the top, the principal executive in our organization, and I sent the information to him. When that didn't work, I sent it directly to the Secretary. When that didn't work, I went to my Congressman. So I think that we have to put something in place which would allow VA employees to fast-track the grievance process.

And it depends on the variation. If it's something, me and supervisor doesn't get along, well, that can go through a normal process. If it's about patient care and the welfare of human beings or lost applications to people who have served in Iraq and Afghanistan, that needs to be fast-tracked and brought to the forefront.

In Ms. Hughes' case, when she was conducting the investigation of the 2,000 missing applications, once the Director said stop, there was no recourse for her. And so I think we've got to find something to put in place to allow these complaints to kind of go to the forefront based upon the severity and the critical nature that they represent.

Mr. RUNYAN. And with my remaining time, Dr. Mathews, I mean, you made the statement. Do you have a sense if central of-

fice sees this as an issue? Because it seems like there's a disconnect.

Dr. HEAD. Well, there is a disconnect, and, you know, I really don't believe any of the data that the VA puts out, unfortunately. And, you know, we have to have data integrity, and how we, you know, are basically talking about ways to make that happen, and that at least at this time, maybe for a temporary period of time, we need to have an external agency that has higher integrity than the VA looking into the data, looking into these complaints and triaging as to what needs to happen first and what can wait.

And unfortunately, the VA has demonstrated over and over again that they are not able to police themselves. They are not able to come up with honest, negative information. And it, again, is not an academic exercise; it really hurts the lives of our veterans.

Mr. RUNYAN. Thank you.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you.

Ms. Kuster, you are recognized for 5 minutes.

Ms. KUSTER. Thank you, Mr. Chair, and thank you to all of you for your courage in coming forward. We appreciate it, and we understand the risk that you are taking, and just know that we are your witness. If there is anything that happens to you, please be in touch with our offices.

I would like to follow up on Dr. Ruiz's questions to Dr. Head and Dr. Mitchell. In the private sector, in the healthcare field, we have a process of quality assurance that sounds like maybe what you're doing in your root cause analysis, but to get at the issues that impact patient safety and the safety of veterans, but also some of the staffing issues, Dr. Mitchell, that you raised in your testimony.

Is there any type of process within the VA for sharing best practices or for determining what are effective mechanisms? The types of problems that you are describing we perhaps are fortunate not to have. I have toured our VA facilities in Manchester, New Hampshire, and White River Junction, Vermont, and found very high levels of competence, and access and quality of care. So I'm wondering, what is the practice of sharing best practices, and how would you go about improving upon that?

Dr. HEAD. Well, in 2012, November of 2012, I noticed a spike, increased number of veterans who were presenting with advanced cancer. And once I did a little research, I found they were in the system, but, for whatever reason, they weren't either receiving a screen, like a colonoscopy, or there wasn't really follow-up, and that troubled me.

So I sent the email to the Director around 1:30 in the morning saying that we should follow the practices that are well established in the community and the standard of care within the National Institutes of Health. And it's around 50 pages. There are flow diagrams, standard operating procedures to kind of make it basically idiot-proof that when you have certain patients that come in, that you should have guidelines of when the patient should be screened, when they should receive treatment; that if they have cancer, they need to be presented a multidisciplinary team so we can expedite therapy, because most therapy is a multimodality of either chemotherapy, radiation therapy, surgery, if possible.

For whatever reason, this was not happening in the number of patients that I saw. And so I encourage us to adopt some of those things. And but——

Ms. KUSTER. Did you have any success with that?

Dr. HEAD. Well, I had some success, but I think one veteran who's in the system who doesn't receive the screenings necessary is too many, in my opinion. And so I thought that we should have more—those type of ideas should always be flowing within the VA to have procedures so we don't miss the veterans. No veteran should be left behind, even if it's cancer.

Ms. KUSTER. And is there any process for quality improvement? Is there any—do you have any procedures or protocols within the VA system that you could bring forward these types of standards and procedures?

Dr. HEAD. That's what I'd like to do. But, you know, I can't say I've been able to do it because of the other activities I've had to be involved in. But——

Ms. KUSTER. Dr. Mitchell, have you had any experience with that?

Dr. MITCHELL. Yeah. There is a whole quality assurance division in our VA. And certainly I was on an email group for ER physicians, the Directors, and we shared ideas. The problem is what we need is a best practice of how to overcome bad management, because we all knew we were all suffering from short staffing. We were all suffering from other issues, problems with nurse triage, other things. We just couldn't get anyone in our facility to listen to us that had the power to make the change. Again——

Ms. KUSTER. And with the short staffing, were you told that that was a fiscal issue, that you couldn't hire people, or is it an issue of timing in terms of getting professionals credentialed?

Dr. MITCHELL. The reason varies depending on the week. It can be because we're short, there's a hiring freeze. It can be there aren't enough good applicants, which is often the case. A lot of times there are fantastic applicants, but the process of credentialing them takes 8 or 9 months, in which case they've already found another job.

Ms. KUSTER. And just briefly, and I have very little time left, but I just want to say, Dr. Head, having reviewed your testimony in the various lawsuits, I'm extremely concerned about the issue of racial bias in your record, and I just want to commend you on your courage and your professionalism and admire the strength that it takes for you to just get up and go to work every single day. So thank you for coming here today. I appreciate it.

Dr. HEAD. That is quite a compliment. Thank you very much.

Ms. KUSTER. Thank you, Mr. Chair.

The CHAIRMAN. Thank you.

Dr. Benishek, you're recognized for 5 minutes.

Mr. BENISHEK. Thank you, Mr. Chairman. I.

Want to thank you all for your very, very powerful testimony that you presented here today. You know, I was a VA doctor for a long time myself, and, you know, I really feel that there's a great deal of difficulty in communicating with leadership.

And I think, Dr. Mitchell, you sort of mentioned it, too, is that when you find problems within the VA as a physician, you try to

tell somebody up the ladder what the problem is in order to improve care, there is no one that seems to be able to get something done. I mean, you talk to your Chief of Surgery or the Chief of Psychiatry, the Chief of the ER and then you talk to the Chief of Staff.

Is the Chief of Staff usually an advocate for the physician, or are they an advocate for the administration? Or who do you go to then? My concern is that physicians don't have enough access to management to make changes that they recognize need to be done. How can we do that better? Let me ask all of you how to do that.

Dr. Mathews, why don't you start.

Dr. HEAD. Yeah. Well, you know, in my particular case, you know, I was the Chief of Psychiatry, and I was going to the Chief of Staff, and it seems like, you know, these things don't register, like you said. It's not given the right urgency or the right priority.

Mr. BENISHEK. Does the Chief of Staff have somebody that they can talk to up higher on the list? You know, I mean, that seems to be the place where it seems to stop, from my experience working there. Is that the problem, you think?

Dr. HEAD. Well, you know, I really do not know what the Chief of Staff——

Mr. BENISHEK. Dr. Head, what's your opinion about that?

Dr. HEAD. Well, you know, one person's Chief of Staff came to my defense, and this person was severely punished and pushed out. So I do think there are a good people in Chief of Staff. In our hospital, we have one of the largest VAs in the country, there is close to 12 Chief of Staff members. You know, some of them know that retaliation is a problem, and then others are part of it, so——

Mr. BENISHEK. Dr. Mitchell, what do you think about that?

Dr. MITCHELL. My experience with Chief of Staff, and we certainly run through several at the Phoenix VA, is that generally they advocate for themselves. We do have the option of going above to the VISN level, but often they just refer you back to the facility director.

Every physician has the ability to go to the local union office and say they want to organize. There are certainly some physician groups that have done that that have gotten memos of understandings to stop the overload of physician panels and things like that.

But the physicians have to organize themselves in whatever way they want to approach that, whether it's through the union or whether it's by themselves, and then going through management. The problem is everyone is too afraid to do anything because the risk of retaliation is so real, and that's the loss of your livelihood at best. At worst, it's the loss of your career and your ability to be employed anywhere within the vicinity of that VA.

Mr. BENISHEK. Can you tell me more about this—I understand there is kind of a sham peer review thing. Can you explain that to me again?

Dr. MITCHELL. Normally a legitimate peer review is where someone has questioned the ability of a physician to meet——

Mr. BENISHEK. Well, I'm familiar with M&M, morbid and mortality conference. That's where we typically would do that in my hospital setting.

Dr. MITCHELL. It's more than just an M&M, though. Everyone can make a mistake, and things can be overlooked. A peer review is where you are so afraid that this person is not practicing up to the standard of care that you pull a large section of cases and have his peers review them to see if there are truly significant deficits in the person's ability to practice medicine. That is only supposed to be done in extreme cases where there truly is legitimate concerns that this physician is not up to standard as far as practice.

Sham peer review is where you have the ability to call a review, a major review, of a physician's cases. If you can't find anything that they have done wrong that's significant, then what you can do is put kind of subjective findings; well, this physician, you know, doesn't necessarily practice with the most professional ability to interact with people, or something very vague, very subjective.

What happens is that in the medical community, peer reviews are only done if there are huge red flags. That's the reason why it's important that if you were ever the subject of a peer review, you have to report it on a license or a job application. Most people that don't work in the VA don't realize that peer reviews are done as punitive actions in the VA in order to sabotage a physician's credibility. It's also incredibly demeaning and debasing for a physician to go through a peer review practice because they are practicing professionally. Psychologically it's so stressful, most physicians would quit.

Mr. BENISHEK. This is done by other physicians on the staff with you, though.

Dr. MITCHELL. Yeah. Usually it's the Administrator and then friends of the Administrator. They all get together and say, this guy, you know——

Mr. BENISHEK. There is not a physician, then, you're saying? There is not really peer review.

Dr. MITCHELL. No, it's physicians. Just because someone has an M.D. doesn't mean they have ethics.

Mr. BENISHEK. I guess I'm out of time.

The CHAIRMAN. Thank you, Doctor.

Mr. Walz, you're recognized for 5 minutes.

Mr. WALZ. Well, thank you, Mr. Chairman, and, again, I will associate myself with my colleagues. Thank you, all, for the work you are doing, because you understand the corrosive nature of this is not just the personal damage that is done to you, but, as each of you have so clearly stated, and eloquently and with passion stated, it hurts our veterans. That's what's at stake here, too, so I appreciate that.

Mr. DAVIS, you summed up what I've been beating this drum for years: There is no national veterans strategy. When I asked them what their strategy was, they give me a goal that they're going to get to. There's no strategy how to get there. So it doesn't surprise me when you call the White House, they're not quite sure who to send, they're not quite sure who to go with, because it doesn't work that way.

I've been asking for a quadrennial vets review just like we do in DOD so that we can have a strategy, we can resource it correctly, and we can have the things in place to make the corrections, but that is lacking.

And I would go further on this, and I could tell each of you that we're coming to this how do we get this. I am with Dr. Mathews. I will tell you, Dr. Mathews, I am not putting my veterans' health care nor my reputation on the data I receive. So when people ask me how are the local facilities doing, I am worried to tell them. I said, well, the data they've given us is showing this. I'm out there every day. I'm someone who has been there.

But here we sat, and my colleagues will tell you this, months ago we got flagged after the audit, and we had some of our facilities flagged. And they sat right there, and those of you sitting in the VA behind there, you can be sure that we want an answer, and we will ask you again tonight, whether it's your field or not, why don't we know what happened at Rochester? Why is it flagged? Why is it flagged? Can somebody speak to that? Can somebody say? And tonight we get general counsel. They all blamed you in all the other hearings, so now you get the answer tonight.

But I would suggest this—and not to point at you, because I know the good work that is going on. I would submit to all of us here, the watchdog on this and the outside agency to look at this is here, is us. We are given the constitutional right to do it.

When I go home, I'm asked about this, and I should be held accountable of where this is asking, but we don't know where to get it. And I would suggest that this committee is the most nonpartisan in many cases. The staff that sits up here, I can go to either one, the majority and minority, and get answers to fix problems for veterans because that's what they do, but it's been historically understaffed.

I would like to send this staff out there to tell me what's happening in St. Louis, to what's happening in Los Angeles, come back to report so I get it from the horse's mouth, because right now I can't trust where that data's coming.

So that's my soapbox to each of you. And we all feel very strongly, but we have to come up with a solution. We have to have an accountability. We have the constitutional power. We need to get some authority to be able to do this. We need to add to these good staffers who are up here so that they can get out there and ask the questions and start doing this.

And I would suggest or put forward to each of you, maybe I'm a little Pollyannaish on this, but, I mean, it's just beyond the pale to me that there's people acting—I'm a high school teacher. This is bullying. I mean, this is what it amounts to. You talk about horizontal violence. There's been a lot of research done on this. Here's what happens when you have that: Increased turnover; lost productivity; employee loss of motivation, commitment, satisfaction; lots of lateral transfers, lawsuits; and adverse impact on patients' customer satisfaction. We know all that. That research is out there.

The question I have is that we can say it's the VA, we can go down this it never happened in the private sector. It happens in the private sector, too. This is about people and accountability.

What we need to figure out: National strategy, put in place the accountability pieces, have the elected people who get here by the public's will who want to get this right, and then have the resources and the power to make sure it happens. Because there's

wonderful people—you work with them every day—providing great care.

Mr. WALZ. One question to you, Dr. Mitchell. You said, over 16 years, the care has improved at Phoenix, the care of veterans. How do you simultaneously improve care while this corrosive culture has existed? Is that just the quality of the people that are coming there to work?

Dr. MITCHELL. Yeah, what you have is you have an incredible force for change in your employees. The majority of employees are veterans themselves or family members of veterans. They give incredibly good care, whether it's direct patient care or whether it's indirect care.

And so, despite the fact that there's a knot that their stomach when they try to get in their car to go to work, despite the fact that they know that their supervisors are going to harass them all during the day, they try to give the best care that——

Mr. WALZ. So that's really happening? So when someone says the care—when my veterans say the care at the VA, once you get in, if you can get past that—I would ask each of you, have you been in different VA hospitals? Does Minneapolis look like L.A.?

Dr. MITCHELL. I've only been in Phoenix, and we give tons of really good care. The problem is, with healthcare needs, when you ignore them, a veteran falls through the cracks, and that has devastating consequences to their health.

So what we're focusing on is the hundreds of thousands of cases where there's been bad care given. We shouldn't lose sight of the fact that we give millions of instances of quality patient care. And that's the reason why the VA is worth saving, because our employees make it worth saving.

Mr. WALZ. Well, our young residents and our young graduates of our medical institutions, will they still choose to continue to go to the VA like you did and give careers? Because my fear is this: We drive them away, we make it so unattractive, we make it so poisoned that we can't—and I'd just——

Dr. MITCHELL. I wouldn't recommend, in the current state, that people get a job at the VA as a physician until there's some guarantee that whistleblower retaliation will be protected, that the pay will be the commensurate with what's in the community, that there's a professional work environment. Everyone just—I'm really proud to be a VA physician——

Mr. WALZ. That's a nightmare scenario for me, because we know what the numbers look like, we know the care that our veterans are going to need, and we've got to get this figured out.

So I yield back. Thank you, Chairman.

The CHAIRMAN. Thank you, Mr. Walz.

Mr. Huelskamp, you're recognized for 5 minutes.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

I appreciate the witnesses coming and visiting with us tonight and sharing your story.

And I'm particularly troubled by the last comment, the suggestion, the recommendation that folks look for employment elsewhere until these problems are fixed, Dr. Mitchell.

One thing I would ask for each you: Each named superiors or other senior staff who ignored your pleas, violated your confiden-

tiality, knowingly injured veterans or placed them at risk. Do you know if any of these have been punished or censured by the VA?

I'll start with you, Dr. Mathews.

Dr. HEAD. No, I do not know. And, you know, with the whistleblower retaliation and cooking up numbers, it's basically sending all the wrong messages, that it doesn't matter, care is optional, we'll protect you, we'll come up with the numbers. You know, it's so corrosive.

And, you know, going back to the point of Mr. Walz, I started the Washington University residents rotating through the VA. And I had one resident, who was very good, who wanted to join, who did not. And I had two other people I knew in the community who were excellent psychiatrists, trained at very good places. And they came and interviewed, but, you know, they couldn't, they didn't want to work in these situations where—they were wanting to join because I wanted to build a good mental health clinic there. And then it was inconceivable that, you know, they just removed me from that position.

So this is a very corrosive—it's very demoralizing to a lot of the ethical people who work there, as well, because they see either they have to leave or they have to just keep quiet and suffocate internally. I think that there are no other choices there.

Mr. HUELSKAMP. So there's no doubt in your mind other employees see the mistreatment, the violations, and see your treatment and choose to remain silent in the face of that.

Dr. HEAD. I absolutely know that for a fact, that that's the case.

Mr. HUELSKAMP. What would you recommend—and all members of the committee have probably heard from constituents since this scandal really broke open, and the committee's been looking at this for a number of years. But what would you recommend to whistleblowers that have knowledge, have this concern, that share your doubts about how they'll be treated? What should they do? Who should they turn to?

I've had three to four whistleblowers. I showed up unannounced for a surprise visit to a facility, somehow was able to get in and started to uncover things. But what do I tell whistleblowers when they say, Congressman, this is what we've seen happen, but we're not going to tell you our name because we're afraid we're going to lose our job? What should I tell them?

Dr. MITCHELL. Well, at this point, you could give them my name, and I'll report it. Since I've already got a target on my back, it doesn't matter.

Actually, that's what's happening. I've had multiple phone calls from physicians from VAs across the country. There's a VA facility that's bedsore-free, not because they don't have bedsores, but because the physicians and the nurses were forbidden to document bedsores.

There's several—and there are many, many, many issues. I've certainly contacted Jeff Miller's, or Representative Miller's office and gotten a phone number of someone who said that they would maintain the confidentiality and investigate. And, at this point, I would tell whistleblowers to go to the Congressman or see Mr. Miller. And that's a problem above my pay grade.

Mr. HUELSKAMP. Yeah, and that's what's happened in our office.

Mr. Davis?

Mr. DAVIS. Yeah. I would say, I've had several whistleblowers come to me directly, and I've shared their testimony with the committee, and I've actually read some of their statements into the record. And I, too, would say those that I know are familiar with the administrative process side of the House, I'll be more than happy to take their whistleblower complaint to the public. I think that's our ability to do what we can. My background is communications, so I was able to navigate through the press process a little bit quicker than most whistleblowers.

And I think that's the key thing. It doesn't take everyone to do the same thing. Some people may be comfortable at just going to the IG. Some may be comfortable going to their Representative or Senator. Some may be comfortable going to the press. But there's different levels of whistleblowing. You don't have to go as far as we did. I think we're something—a little bit, in some cases, the exception. But I think there are different ways you can get the information out.

And there are different people who want to report it. There's interest groups, there are civil groups, there are veteran service organizations who would be more than happy to get the information. They have the right connection with many of the leaders in Congress. There are different ways you can get the information out. But I will tell you this: You feel much better when you say something versus holding it in.

Mr. HUELSKAMP. And I have no doubt there are VA employees that are as concerned as you are listening tonight or seeing the comments. And, I might add, there are probably—there's folks out there probably tearing all four of you down for having the courage and bravery to show up.

But recognize, if you're listening, step forward. And my office, other offices, we'll be there to carry that water for brave employees like yourself. So I appreciate your commitment.

Mr. Chairman, I——

Dr. MITCHELL. Excuse me, I wanted to make a clarification. Even though I said I would not recommend getting a job at the VA, I actually am not looking for a job elsewhere. The VA is really important work. I would tell those people they're working—they'd be working with great people, but they have to have a true understanding of the administrative culture and where it stands today and then make the decision.

Mr. HUELSKAMP. Yeah, Dr. Mitchell, there is no doubt in my mind your commitment to our veterans, so thank you.

And, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Huelskamp.

Mr. O'Rourke, you're recognized for 5 minutes.

Mr. O'ROURKE. Thank you, Mr. Chairman.

To follow up on Mr. Huelskamp's statement, Dr. Mitchell, I couldn't help wondering during your testimony and in the answer to many of the questions that were asked of you, as you detailed the ostracism that you endured, the being shunted aside when you made problems for management, ending up in a position now where you say you're doing good but it wasn't the position that you signed up for, and then I know you just clarified it but earlier say-

ing you would recommend to somebody who's thinking about working for the VA, not now, not until we get accountability and oversight and protection for whistleblowers, I couldn't help wondering why you stayed.

Dr. MITCHELL. I stay for a couple of reasons. One, the work is incredibly fulfilling and important. I went back to medical school specifically to be a VA physician because I saw there was a great need.

Everyone who works at the VA knows there are limitations. That's—we're a Federal department; there are limitations. The veterans are so grateful for the quality of care. You'll see such a wide variety of people at the VA and, certainly, disease states. From a physician standpoint, it's interesting. My background is geriatrics. It was a playing field for geriatric. In fact, ER was geriatric urgent medicine at its best. It's very interesting, it's very fulfilling.

I don't always feel so resilient, though, as a physician there. I'm definitely tenacious, I'll give myself that, but sometimes it's really hard. There is that knot in the center of your stomach driving in, where you just don't want to show up because, as much as you love the veterans, the administration wears you down, and you begin to doubt your own professional abilities.

Mr. O'ROURKE. Just from your answer to my question and what you said earlier—and, really, for everyone on the panel, I mean, we keep asking about culture, which is the most important issue but probably the most difficult task before us as a country in terms of turning around the VA, but you really represent the culture that I think we're looking for and that we want to see throughout the system, not just at the provider level, at management, at the Secretary level, on through this committee, and, again, as a country. So I want to thank you for that and thank you for the example that you provide.

But I also want to follow up on another comment that you made. You mentioned surviving 16 years of this. And these problems didn't just occur, you know, under this administration or the administration prior to that, but they're longstanding.

And I remember—I've been here for a year and a half, and one of the first hearings I attended was a joint hearing with the Senate VA Committee, where we heard from the veteran service organizations. And I remember a commander coming before us and saying, you know, this is my—I don't know what the exact number was—this is the 32nd time I've appeared here, I've been coming up for decades, and I've been saying the same things over and over again.

So you said that this is a system worth saving, but my question to you is, is it salvageable?

Dr. MITCHELL. Oh, yes. You've got thousands and thousands of employees that are dedicated to the veterans and the welfare of the veterans. I am really discouraged when I hear people say the VA is too big to change. You have an entire group of people that are ready for a revolution, and they want this. They want a productive healthcare system delivering good care.

The horizontal violence has to stop. That was one of the implications of whistleblower retaliations, that it affects care because you don't speak up to say what the problems are because you're afraid of the repercussions. The corollary to that is that you begin to—

it's a pressure cooker—you begin to pick on each other. Gossiping, bullying, exclusive cliques at work. We kind of feed on each other because we're don't know what—we're under so much pressure. And that needs to stop, too.

Mr. O'ROURKE. Yeah.

I wanted to—and each of you have given us some ideas and some direction on how we can make those changes, but I do wonder how we're going to be able to do it after so many years and so many fundamental systemic problems.

Dr. Mathews brings up the issue of not being able to trust the integrity of the data, which has become obvious to all of us. And I commend your efforts to measure those things that are important to patient care and outcomes in the facility at which you worked. We've been trying to do that in El Paso. We've seen similar attrition rates of over 40 percent of veterans seeking mental health who can't get an appointment just give up and stop trying. And we can only, right now, because we don't have the full story, wonder at the outcomes.

Mr. Flores and I and Mr. Jolly and others on the committee introduced the Ask Veterans Act, which would not rely on the VA to tell us how the VA is doing but ask veterans to do exactly what you are trying to measure in your facility.

So, anyhow, let me just conclude by thanking you all for what you're doing. And I hope that the recommendations and direction that you gave us tonight lead to some of the cultural changes that we all know are essential to turning the VA around. So thank you.

Mr. Chair, I yield back.

The CHAIRMAN. Thank you, sir.

Mr. Coffman, you're recognized for 5 minutes.

Mr. COFFMAN. Thank you, Mr. Chairman.

Thank you all for stepping forward as whistleblowers. I believe that the rank-and-file in the Veterans Administration are, in fact, employees that truly care about serving the needs of our Nation's veterans. And without the whistleblowers, such as yourself, who have had the courage to step forward, we would never know the problems that exist within the Veterans Administration, because none of the problems have ever been self-identified by the leadership within the Veterans Administration. We've always been aware of them simply by whistleblowers coming forward and sharing with us the reality of what is occurring on the ground within the Veterans Administration, particularly the Veterans Health Administration.

Mr. Davis, one thing, I think, when we became aware of—started to become aware of the magnitude of the crisis, it was concerning the patient wait times and the fraudulent changes in terms of those records, often fueled by a drive for bonuses.

Mr. DAVIS. Uh-huh.

Mr. COFFMAN. But what you're saying is, actually, the problem was much deeper than simply patient wait times, that they were also denying people inside the system. Is that correct?

Mr. DAVIS. They were actually——

Mr. COFFMAN. To get into the system.

Mr. DAVIS [continuing]. Neglecting the applications. And I think this is where I think we have to look at—you can only get the appointment if you're enrolled.

Mr. COFFMAN. Oh, okay.

Mr. DAVIS. And so we have systemic problems in the enrollment system.

And to give you some context—you may hear this from the next panel—the office where I work, the Health Eligibility Center, is about to start what they're calling a command center. This is something that they're going to probably send to VA leadership, perhaps even this committee.

But I want you to understand that real change will only come from real solutions at VA. Currently, this is part of what I call the gimmicks that go on at VA. We announce something, give it a new name, and we send it out, making the public and the leadership on the Hill think there's a change.

But I will tell you, when you look at this document, the communication training people perform communication training every day. That's not anything new. The enrollment people perform the enrollment task. The call center people perform the call center task. This is not going to change anything. The strategy is to take people from the fifth floor and put them in a room on the second floor. This is what constitutes responding to veteran concerns at VA.

And so I think what has to happen, what I would encourage the committee to do is follow something that I do think does work in business, and that is make people sign off on the reports they turn into the Congress. I can tell you what's disappointing to me, as a citizen and a VA employee, is to watch leader after leader in the VA sit in these chairs and say, "I don't know. I'll get back to you. So-and-so was supposed to do that. General Counsel won't let me." That, to me, is just inefficient. If you're going to be in a leadership position, you first need to lead. And so making people sign off on quarterly reports to say that I own the data that I turn in, I own the enrollment records that we turn in.

I doubt very many people in this room knew there was a 600,000 pending backlog at VA or that, last year, 40,000 applications, 18,000 or more from Iraq and Afghanistan veterans. If people would've known that, something could've happened. If those reports had to be signed off on by people like Ms. Harbin, people like Mr. Matkovsky, people in positions that were held formerly by Dr. Jesse, Dr. Petzel——

Mr. COFFMAN. Uh-huh.

Mr. DAVIS [continuing]. This is where the change comes from.

Mr. COFFMAN. Right.

Mr. DAVIS. But you've got to document. One of the problems we have as whistleblowers, the first time you go to make something public, they tell you, "Well, where's your proof? Where's the document?" Well, most people are not going to sign a document, "I'm deleting applications. I failed to process applications." But this is the type of conversation——

Mr. COFFMAN. Sure.

Mr. DAVIS [continuing]. You get when you go and talk to them.

Mr. COFFMAN. Well, let me just put it this way. And if you all could comment on this. The Veterans Administration is so dysfunc-

tional right now in terms of its leadership, in terms of the culture, as well, so, I mean, having a new Secretary come in, the culture is still there. I mean, I hope that the new Secretary can make the appropriate changes, but it's going to be difficult.

Do you all believe that there should be an entity really outside of the Veterans Administration for which a whistleblower reports?

To Mr. Davis, and then let me go down to the physicians here.

Mr. DAVIS. I would absolutely say, yes, it's imperative. If you really want real change and a true whistleblower environment where people will come forward, you have to take the policing power outside of VA.

Mr. COFFMAN. Dr. Mitchell?

Dr. MITCHELL. I would agree. No one trusts the VA to handle their own problems, nor report it to them.

Mr. COFFMAN. Dr. Head?

Dr. HEAD. I agree.

Mr. COFFMAN. Dr. Mathews?

Dr. HEAD. I completely agree. I mean, VA doesn't acknowledge a problem exists. So, you know, I mean, it's absurd to expect that they would want to fix it. Their position has been that there is no problem. And we have the numbers to prove it.

Mr. COFFMAN. Okay.

Mr. Chairman, thank you. I yield back.

The CHAIRMAN. Thank you, Mr. COFFMAN.

Ms. Titus, you're recognized for 5 minutes.

Ms. TITUS. Thank you, Mr. Chairman.

Thank you for being here.

I realize that there's a pattern that leads us to the conclusion we need to go outside the VA. But aren't we at a point where there's a real opportunity to make a change because about nine of the top positions, including the Secretary, are vacant right now?

So if we can bring in a new leadership team and impress upon them the need for this accountability, which we have heard repeated in every hearing, whether it's on the backlog or the bonuses or whistleblowers, that this is the message, that maybe we're at a point where we can start to make that difference?

I'm sorry that Mr. McDonald can't come in here and hear what we are hearing. I know that Sloan Gibson is scheduled to come, but, Mr. Chairman, we need to get the new Secretary in here as soon as we can, because he needs to hear the kind of things that we're hearing so that we can move this in a new direction.

I would just ask y'all: You're located kind of near my district in Las Vegas. We have a new hospital. I met with some of the emergency room doctors there. It was at my invitation. They were scared to come. They aren't as brave as y'all are. They wanted to be sure that they knew I invited them, because they feared some retaliation.

Have you heard—and you travel in small circles. Have you had any contact with people at the Las Vegas hospital or are familiar with any whistleblower problems there?

Dr. Head or Dr. Mitchell?

Dr. MITCHELL. No. The individuals who've contacted me are from across the country but not from Las Vegas.

Dr. HEAD. No, I haven't. And we've had a significant number of our staff actually relocate in Las Vegas when they were building their new hospital, but I haven't heard of any whistleblower problems.

Ms. TITUS. Well, I'm glad to hear that.

One other thing I wanted to ask you, Dr. Head, you mentioned that the first response to a whistleblower is to try to impugn their integrity. And one of the examples you mentioned is that they often say is, well, you're just a disgruntled employee because you didn't get the bonus that you wanted.

I just wonder, could you talk about maybe the possible nexus between bonuses and whistleblowing? Are people getting paid to be quiet?

Dr. HEAD. I don't—well, I have no evidence of people getting paid to be quiet.

But I do think, you know, there is a tendency to try to generate a motive for why someone is coming forward and telling the truth or reporting wrongdoing, and it's often associated with somehow a personal gain from a whistleblower. But I'll tell you, there is no personal gain from being a whistleblower. Even when you go through long litigation and you ultimately win, you know, there's no financial incentive whatsoever——

Ms. TITUS. Right.

Dr. HEAD [continuing]. Believe me.

Ms. TITUS. Oh, I'm sure of that. I was thinking of just the opposite, that you keep people kind of tamped down and not speaking up if you give them regular bonuses. And——

Dr. HEAD. I don't——

Ms. TITUS [continuing]. That maybe keeps that culture of silence that you mentioned.

Dr. HEAD. I think you'll see that the bonuses are usually among the Chief of Staff or higher-ups who are receiving those bonuses. You're not necessarily receiving bonuses at the level of some of these whistleblowers.

Ms. TITUS. Dr. Mathews or Dr. Mitchell?

Dr. HEAD. You know, in my experience at the St. Louis VA, I had productivity data or had data for every psychiatrist as to the number of patients being seen. And I know that there's only one psychiatrist, perhaps, who did not get the full performance pay, which is, you know, what could be considered a bonus, and that's me. I got 50 percent, and, actually, not for the wrong reason. They were correct, because I only could accomplish probably less than 50 percent of what I set out to do.

But it sends a very wrong message, that, you know, the way to go about in the VA is to just keep quiet, just do what you want to do, and you will not get into trouble for not working. You know, the only reason, I think, one can get into trouble is by identifying problems and coming forward. So that has to change.

And I think, you know, it's a complex issue if you call it "culture," but I think the fix to it can be very simple: demanding data integrity and holding people accountable. You know, that once that starts to happen and once some senior positions, not people who resigned who, you know, again, have high integrity that they resigned—I mean, the people resigned because, you know, they have

integrity—but the people who don't care. And those people need to be fired so that it sends the message that this is not—this cannot be tolerated anymore.

So, you know, I would say that you are right. You know, the people who get bonuses are the ones who just keep quiet and keep doing what they're doing.

Ms. TITUS. Dr. Mitchell?

Dr. MITCHELL. Well, there's a difference between a performance measure bonus and proficiency bonus. Performance measure bonus is what you get if your facility has met the performance measures to whatever degree. Most of us that are eligible for those are quite frustrated because the facility never has the resources to meet the performance measures. And so there is a bonus per se, but it is nowhere near—we want to be rewarded for the work we do on our proficiencies.

Our proficiencies are actually how we perform through the year on our own personal merits, and those are subjective. Our administrators, if they like us, can rate us high; if they don't like us, can rate us low and don't necessarily have to give a reason why.

Basically, most people stay quiet just for survival in the VA system, not because there's any benefit one way or the other, at least at my level. I don't know what's in the SES service.

Ms. TITUS. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Wenstrup, you're recognized for 5 minutes.

Mr. WENSTRUP. Thank you, Mr. Chairman.

And I thank all of you for being here tonight.

And as I sit here and listen to your testimony, one of the things that comes in my mind is, somewhere along the line, through your parents or somewhere, someone taught you about doing the right thing and about being able to look in the mirror at the end of the day and know that you're doing the right thing. And I applaud you for that. And know that you're respected by those that matter. And those that don't, they have their own issues. And I appreciate that.

You know, I served in Iraq as a doctor, and we had something that you mentioned tonight, a sense of mission. We had a shared sense of mission, and everyone was on the same page. We're a Reserve unit. We all come from private practice. There's no room for slacking, and the patients were the first priority. And you work through the night if you have to, and you take shifts sleeping. And there's esprit de corps. And wouldn't you love to be able to practice in an environment like that every day?

And the people that I'm talking about, these are our veterans, the ones that provided that type of service and they provided for the others that are our veterans today. And it's really sad for me to hear that there is a need for an agency with a higher integrity than the VA, which was said tonight, that the people in the VA would be willing to accept that they need someone to watch over them because of their lack of integrity.

And Dr. Ruiz brought up mortality and morbidity, and we talked about peer review. What I'm used to with peer review in my hospital was you had people from the same specialty reviewing charts and people that are familiar with the procedures you're talking about, the problems that maybe exist. And you do that to try and make things better. And if someone is really failing, then they have

to go, because the reputation is on the line. And it's not there to be punitive but to make everything better, as far as care.

So my question is, besides whistleblowing, is there any chance for provider input, such as, "We have too much administrative responsibility, we don't get to see patients"; such as, "I need another clinical assistant in here, I need a PA or a medical assistant, then I can see five times more patients"? Or do you have the opportunity to say, "So-and-so is really a poor performer in the clinic, and it's slowing my time down with my patients and I don't get to see as many"? Is that available to you?

I'll start with you, Dr. Mitchell.

Dr. MITCHELL. In that particular form, that's not available.

There are certainly—in section 4 and 5, I talk—especially 4—I talk about the retaliation tactics against providers. And one of them is failing to fill the ancillary services so the provider's clinical time is stretched incredibly thin. There's another one where they overload the provider's patient panel so there's no way they can humanly get through them.

You're not talking—we're not at the level to be able to communicate equally with our administration. We're far below. And anyone that speaks up is retaliated against. We don't have that freedom to speak freely and advocate for patients and ourselves.

Mr. WENSTRUP. And, as you said before, just because you have "M.D." after your name doesn't mean you have ethics. So, in those situations, it may be another doctor, but they're saying, you don't need this, or, we're not listening to you. Would that be correct?

Dr. MITCHELL. Yes, that would be correct. And for a variety of reasons. Certainly, a legitimate reason like, you know, Congress hasn't passed funding, or something like that, we can't hire anyone, that's legitimate. But there are decisions that are made, at least as far as we can tell in the rank-and-file, that are made for the benefit of the administrators, not for the benefit of the facility or the veteran.

Mr. WENSTRUP. Any other input?

Dr. HEAD. You know, I think it's—I think it's mixed. I mean, I've seen extraordinary efforts to move mountains, to, for instance, build a new cath lab in our institution that was definitely needed. There was——

Mr. WENSTRUP. By providers?

Dr. HEAD. Yeah, by providers. Basically, the provider said they would no longer practice their craft in an area they felt endangered veterans. And they were responsive to that. Now, it took a certain amount of receptive, particularly receptive leadership. And it also took very stern providers who, as a group, spoke up and said, this is not right.

And so I did think the response was appropriate in that instance, but other times I think resources are placed in areas where there's too many resources and things. And so, again, you know, it involves leadership.

Mr. WENSTRUP. Real quick. I'm almost out of time.

Dr. HEAD. To quickly add, you know, I was trying to institute a time map of the available time of a physician and what's being provided. That, along with veteran satisfaction, if we have those two accurate measures, we can know which facility is overloaded. You

know, if a physician's time—if they're putting in more than, say, 50 hours or whatever and still if there's a wait time and the veteran satisfaction is not there, then the answer there is more resources.

But in the St. Louis VA, in the mental health, the situation was that the physicians were—the psychiatrists that I was monitoring or I was responsible for were working less than 50 percent of their time. So, you know, the solution there is more accountability and more efficiency; it's not more resources. And we can only know that if we have real data that we can believe.

Mr. WENSTRUP. Correct. Well, thank you very much. I appreciate it.

I yield back.

The CHAIRMAN. Ms. Walorski, you're recognized for 5 minutes.

Mrs. WALORSKI. Thank you, Mr. Chairman.

And I'm grateful, as well, that you're all four here.

And it's interesting that you said something, Mr. Davis, that I find that I relate to, and I can see it even again tonight, and you hear it from members of the committee, as well. But I've been here 18 months, as well. And the typical pattern of how this issue, with the investigation of the VA and looking out for our veterans and making sure they get the health care that we promised them when they fought for our liberty and freedom. And, typically, a panel comes in—and you referenced this—and tells us unbelievably shocking stories—and back to your comment, Dr. Head—that are so shocking and they're so disappointing, they're disappointing to me as an American, horribly disappointing to me as representing veterans in my district, 54,000 of them in Indiana, horribly disappointing, nothing celebratory about it, just shocking.

And, I think, every time I come to these hearings, I want so much for a panel to say, okay, we've turned the corner, you know, we've drilled down, we've routed out the bad actors, we've turned the corner, and now we can hit the reset button, and we have a bright future, and we can promise our fellow Americans and our veterans we have a bright future.

But, again, tonight, you know, we're going to sit here—and Representative Walz alluded to this, as well. You're going to walk out of here, and there's going to be another VA panel—there's been dozens of VA panels—that are going to come in and give us two answers, either that you're not telling the truth or they simply don't have the answers to all the questions that we're going to ask based on your testimony. And that's going to happen again tonight. And if it doesn't happen tonight, I will be absolutely shocked.

But, you know, there are dozens and dozens and dozens of high-ranking members of the VA that come in here and have really absolutely said nothing.

And I guess my question to all of you, but specifically Dr. Mitchell, because the Phoenix facility has kind of been at the apex of this whole kickoff of this urgent reaction time. And one of the things that has floored me is the lack of urgency on the part of the VA, that there's a five-alarm fire and nobody is rushing to put it out.

I'm thinking, if I was in the Phoenix VA and I was responsible for any of the stuff that's been going on in the Phoenix VA that the minute this hit the fan nationally, I would be looking and try-

ing to figure this out double-time and make sure that my facility is the standard and that we've raised the standard and that we've reset the record and we are an example for the rest of the country.

In the 3 months that this has been under the scrutiny of the American people—and the American people have stood up and said they will not tolerate this. This committee has said we're not going to tolerate this either. We're going to drill this down and rout out these back actors to where we can provide the best health care to our veterans.

But have you seen anything, Dr. Mitchell, in the last 3 months in Phoenix that says, wow, what a turnaround, they got the message, people have been fired, they've removed these people, there's a ton of accountability, and there's transparency because of the American people demanding accountability? Have you seen that in the last 3 months in Phoenix, any kind of turnaround?

Dr. MITCHELL. The turnaround I've seen has to do with scheduling. I've actually had consults. I've actually—because the backlogs have been reduced, I've actually put in a consult with the patient, and they've gotten a phone call from the VA during my appointment with the appointment time for the consult.

They've certainly done tremendous work getting the veterans processed. The problem is they only fixed the problem that was in the media. They haven't fixed the patient care problems, the hidden mental health delays, although they're certainly working on that for the psychiatry department.

But it boils down to there are still administrators there who refuse to address nursing retaliation that was directly impeding care for ill patients in the emergency room. There was actually a meeting where five or six of the full-time physicians told the chain of command this, and they said flat-out, "We will not investigate the backlash against Dr. Mitchell."

Mrs. WALORSKI. Well, and we had the Inspector General in here a couple weeks ago, who said that the issue of routing out corruption at the administrative level is not going to stop, it's still actively going on—and you're really corroborating that it's actively going on, against you—until somebody goes to prison and people are fired, that there's actually tangible action taken that, number one, the American people can see; number two, the veterans, to restore some kind of faith and integrity in that system where they're going for health care; and then, thirdly, so your colleagues that you work with, as well, feel like their backs are covered.

How long do you see, if it took a national urgency to move the scheduling issue and it took a resilience on the part of the chairman and the ranking member to really go after this issue and try to reset it, how long do you see, even if we keep pressure up, even if a new VA Secretary comes in—if we don't rout out the corruption, a new VA Secretary won't be any more successful than Shinseki was.

How long do you see it's going to take to turn this around if we keep up the same amount of pressure?

Dr. MITCHELL. I'm not sure I'm in the best position to judge that. What I do know is that the media paid attention to the scheduling issues, and, all of a sudden, I get consults completed within 10

minutes. The media needs to pay attention to the lack-of-ethics issue, and maybe we'll get that turned around.

Mrs. WALORSKI. Absolutely.

And, Mr. Davis, just quickly?

Mr. DAVIS. Yes, I wanted to say that I think we've got to do two things.

I think, first of all, we do need a separate group to look at VA, because, as you alluded to, when the new Secretary comes in——

Mrs. WALORSKI. Yeah.

Mr. DAVIS [continuing]. He or she, whoever finally gets approved by the Senate, will have to deal with the healthcare issue first. They're probably not going to have time to become the chief of police for VA and also make the healthcare reforms. So you're going to need some assistance, even if it's a sunshine law where this operating authority only acts for a period of years until you get VA under control.

The next thing you have to look at, look at performance standards for leadership. Unlike those of my colleagues who work at medical facilities, they may have some legitimate reasons for their challenges in terms of dealing with their leadership group. At our organization, our primary function is to enroll veterans into health care. We stir that away to the ACA project.

And this is not about the politics of the law. This is about VA having a public affairs division here in DC, a national veteran outreach office here in DC, a health system communication office here in DC. And that project was sent down to Atlanta for the sole purpose of a senior executive reaching a performance goal. It had nothing to do with our core business.

I go back to a previous point I make, why you need an outside agency to look at this. We have, again, 600,000, and that rivals the number of people who actually enroll in VA in a given year. So imagine a year's worth of applications just sitting in a pending status. Put this in the context of if we were talking about a bank: 600,000 deposits go in on Monday, we never hear about them for another year or 2. Do you think the walls in that bank would still be standing here today?

Yet the men and women who sacrificed for this country have to deal with this. And why? Not because we don't have the resources. Because we focused on ACA, we focused on the veteran dental insurance program. We create marketing materials for Delta Dental and MetLife. Yet we could put these same little fliers in a post office, in a grocery store, to let people know, hey, if you had a pending application in VA through the years 2000 and 2014, contact such-and-such a number.

The same effort we put in getting senior leadership bonuses and the same interest we put in attaching ourselves to high-profile projects is the same amount of attention that needs to go to veterans.

So I encourage you guys, if nothing else, please make sure that we move to a system that has more data integrity. Require the people who come here and sit on these panels to sign off on the information they turn in to Congress. This way, when they come back, they can't say, "That report was done by somebody else." That's the

only way. Hold them accountable, and do it in public, and do it while the cameras are on.

Mrs. WALORSKI. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Jolly, you're recognized for 5 minutes.

Mr. JOLLY. Thank you, Mr. Chairman.

Dr. Head, what is the relationship between UCLA and the L.A. VA hospital?

Dr. HEAD. Like many of our VA institutions, we have an affiliation agreement. It's a, you know, public institution. And a number of the physicians, surgeons have joint appointments with both their chair counterparts within the university and also with the VA.

Mr. JOLLY. So I ask because you're a very egregious case. And I share my colleagues' comments admiring your courage. But it was a case, ultimately, against UCLA and the Board of Regents of California; is that right?

Dr. HEAD. That's correct.

Mr. JOLLY. And so the settlement, the $4.5 million settlement, was with the Board of Regents of California, not with the VA; is that right?

Dr. HEAD. Well, it's a complicated case. I would say, with my case with the regents, we both satisfactorily agreed to part ways. But, as you have noticed, there's tremendous overlap, and there is a Federal component to that.

Mr. JOLLY. Right. I guess my—so here's my question. And I'm trying to distinguish between the fact pattern and the law on this.

So the incident that you refer to was a June 2006 party, one of the more egregious cases, which was referred to as a UCLA party. Was it strictly a UCLA party, or was it also—was the VA institutionally involved in that?

Dr. HEAD. At that particular party, there were a number of members who were employed as physicians at the VA.

Mr. JOLLY. Right.

Dr. HEAD. And, as you have seen, a component of that was directly related to an investigation that occurred at the VA.

Mr. JOLLY. Right. The facts of the case that led to a settlement with the Board of Regents of California, did the facts also support a claim against the VA and the law simply prohibited you from filing some type of legal action against the VA? Or was the fact pattern specific to UCLA and not to the VA?

Dr. HEAD. I won't comment on the—on the State component of it, but there——

Mr. JOLLY. Well, I guess, I mean, here's my question.

Dr. HEAD. Yes.

Mr. JOLLY. Because it is a very significant case.

Dr. HEAD. Yes.

Mr. JOLLY. Do the facts solely lead you to litigation against UCLA, or does the law prohibit somebody in your position from seeking redress from the VA?

Dr. HEAD. The law allows me to seek redress from the VA. And there is a State component, and there's a Federal component, and——

Mr. JOLLY. But your settlement was strictly on the State side.

Dr. HEAD. That is correct.

Mr. JOLLY. Okay.

Now, for the entire panel, a question for you: Are you familiar with the VA's "Stop the Line" program, the video? It's something that I've seen at my—and that's interesting that you're not, because it's something that has been highlighted by my local VA hospital as a program that every employee sees.

It says, for anybody from custodial staff to a doctor, if they see something that interferes with the delivery of patient care at any level, it says, "Stop the line." You know, it's an imagery, if you will, that any employee has the ability to stop operations immediately out of concern for something that they might see.

I know it's been adopted at a number of different facilities, but none of you are aware of this?

Dr. HEAD. I certainly am not.

Mr. JOLLY. Okay.

Dr. HEAD. More like, "Stop the train wreck."

Mr. JOLLY. Right.

Well, listen, I will be honest with you. It was promoted to me as an effort by the VA to encourage every employee to be able to step up and say there's a problem. But each of you have already stepped forward in a whistleblower capacity and yet have no knowledge of the program, which says to me perhaps it is not as promoted internally as some would suggest it has been.

Dr. HEAD. I would say, I felt alone during this long process that continues. And I find that very disturbing.

Mr. JOLLY. Okay. Very good.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you very much.

Members, I'd like to go ahead to the next panel unless somebody has a burning question that they want to ask.

Thank you very much to the witnesses. We do all appreciate the courage that it took to come here tonight. And we will be watching, and rest assured, if any of you contacts us, we'll all jump to protect you from any further retaliation at the Department. Thank you for being here tonight.

And, Members, we're not going to take a break. We're going to continue on with the next panel.

Okay. Members, we're going to go ahead and call our second panel to the witness table.

Our second panel, we're going to hear from the Honorable Carolyn Lerner, Special Counsel, who is accompanied by Mr. Eric Bachman, Deputy Special Counsel for Litigation and Legal Affairs. From the VA, We will hear from Dr. James Tuchschmidt, Acting Principal Deputy Under Secretary for Health. He is accompanied by Edward C. Huycke, Deputy Medical Inspector for National Assessment at the VA's Office of the Medical Inspector.

If you would please rise again before you get too comfortable. Raise your right hand.

[Witnesses sworn.]

The CHAIRMAN. Thank you very much. If you would take your seats.

As with the first panel, your complete written statements will be made a part of the hearing record.

Ms. Lerner, you are now recognized for 5 minutes.

STATEMENT OF CAROLYN LERNER

Ms. LERNER. Thank you.

Chairman Miller, Ranking Member Michaud, and members of the committee, thank you for the opportunity to testify today about the U.S. Office of Special Counsel and our ongoing work with whistleblowers at the Department of Veterans Affairs.

I am joined today by Deputy Special Counsel Eric Bachman, who is supervising OSC's efforts to protect VA employees from retaliation.

I also want to acknowledge the many employees at the Office of Special Counsel who have been working tirelessly on all of our VA cases. There are too many of them to identify by name, but several of them are here with us this evening.

My statement tonight will focus on three areas: First, the role of the Office of Special Counsel in whistleblower retaliation and whistleblower disclosure cases; second, an overview of OSC's current VA caseload; and, third, some encouraging signs of progress.

OSC is an independent investigative and prosecutorial agency with jurisdiction for over 2 million Federal employees. We have a staff of about 120 and the lowest budget of any Federal law enforcement agency.

We provide a safe channel for employees to disclose government wrongdoing, and we evaluate disclosures using a very high standard of review. If the standard is met, I send the matter to the head of the appropriate agency, who, in turn, is required to investigate and send a report back to me. It was within this statutory framework that we received and are still receiving dozens of disclosures from VA employees from across the country.

The Office of Special Counsel also protects Federal workers from prohibited personnel practices, especially retaliation. In these cases, OSC conducts the investigation and determines if retaliation occurred.

Turning first to VA whistleblower disclosures, we have found that, rather than using the valuable information provided by whistleblowers as an early warning system, the VA often ignores or minimizes problems. This approach has allowed serious issues to fester and grow.

In the numerous cases before our agency, we see a pattern where the VA, in particular the VA's Office of Medical Inspector, admits to serious deficiencies in patient care, yet implausibly denies any impact on veterans' health. The impact of this denial has been to hide many of the issues which have only recently come to light.

My written testimony provides several examples of this approach, but I want to highlight one egregious example about patient neglect in a long-term VA mental healthcare facility in Brockton, Massachusetts. Specifically, the OMI report substantiated allegations that two veterans with severe psychiatric conditions waited 7 and 8 years, respectively, to get mental health treatment. Despite these findings, OMI denied that this neglect had any negative impact on patient care. This unsupportable conclusion is indicative of many other cases we have reviewed and reported on.

Turning now to retaliation cases, OSC has received scores of complaints from VA employees alleging retaliation. We currently have 67 active investigations into retaliation complaints from employees who reported health and safety concerns. These complaints come from 28 States and 45 separate facilities, and the number increases daily. Since June 1st, we have received 25 new retaliation complaints.

In addition to these ongoing investigations, we are taking several steps to resolve these complaints. For example, we've reallocated staff and resources to investigate reprisal cases, and we now have a priority intake process for VA cases. And in an effort to find ways to work constructively with the VA, both my staff and I have met with many VA officials, including Acting Secretary Gibson.

I do think it's very important to note the encouraging recent signs that we have seen from the VA leadership. There appears to be a new willingness to listen to concerns raised by whistleblowers, act on them appropriately, and ensure that employees are protected for speaking out.

When I met recently with Acting Secretary Gibson, he committed to resolving meritorious whistleblower complaints on an expedited basis. If this happens, it will avoid the need for lengthy investigations and help whistleblowers who have suffered retaliation get back on their feet quickly. It will also send a very powerful message to other VA employees that if they have the courage to report wrongdoing the VA will take prompt action to protect them from retaliation.

In conclusion, I want to applaud the courageous VA employees who are speaking out. These problems would not have come to light but for the information they have provided. We look forward to working with the whistleblowers, with this committee, and with the VA to find solutions to these ongoing problems. And we look forward to answering any questions that the committee may have.

Thank you.

Office of Special Counsel

The CHAIRMAN. Thank you, Ms. Lerner.

[THE PREPARED STATEMENT OF CAROLYN LERNER, APPEARS IN THE APPENDIX]

Dr. Tuchschmidt, you are now recognized for 5 minutes.

STATEMENT OF JAMES TUCHSCHMIDT, M.D.

Dr. TUCHSCHMIDT. Thank you. Good evening, Chairman Miller, Ranking Member Michaud, and to the committee.

I know I come here tonight with my credibility in question. There is no doubt about that. I have some prepared remarks, but I'd rather just speak my mind.

We failed in the trust that America has placed in us to fulfill our mission. Patients have clearly waited too long for care that they have earned. And I would agree with Congresswoman Kirkpatrick that it seems that it took a whistleblower and a crisis to expose the events and get us focused on those—correcting those deficiencies.

As I sat and listened to the first panel, I, quite frankly, was very disheartened that staff feel that they cannot fix problems in the organization that affect safety, quality, and our business integrity. I

think this is unacceptable. The Acting Secretary has made it clear that this is unacceptable. He sent a memo to all employees on June the 13th indicating that that kind of behavior was unacceptable and that we would not tolerate retaliation.

The stories I heard tonight clearly depict, in my mind, a broken system. I have to believe, have to hope, that these things are exceptions and not the rule. I know that there are many, many good employees in this organization who work tirelessly on the behalf of veterans, and there are many managers and executives within the organization that do the same.

The sad part of it is that, for every whistleblower who comes forward and says something, there is someone out there who is quiet, who tries, can't make any effort, and just goes away. And those, unfortunately, leave risks in our system and deficiencies that are not fixed.

I apologize to every one of our employees who feels that their voice has been silenced, that their passion has been stifled, because that's just not acceptable, and it's certainly not what I stand for.

Quite frankly, I'm past being upset and mad and angry about this. I'm very disillusioned and sickened by all of this. I think that—I can't believe that I'm at a point in the organization where we are, of a place that I was so proud of and have worked so hard to make it a great place.

I left private medicine to come to work for the VA. I did that because I thought there was no nobler mission, no more greater devotion than what I'm doing. I did not come to work for a mediocre healthcare system. I came to work for one of the best healthcare systems in the country. And I believe the system can be the best healthcare system in the country once again.

The problems we have can be fixed. We went through probably one of the greatest transformations in the healthcare industry in the mid-1990s to become what I think was a great, great system, and I have hope and confidence that we can do that again.

So, Mr. Chairman, that really concludes my remarks, and I promise you we will do our best to answer your questions.

[THE PREPARED STATEMENT OF JAMES TUCHSCHMIDT, APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you for your comments. Still, there are a lot of things that we need to cover.

And I was looking over the testimony of the OSC, where they described an issue at the Montgomery VA, where, in fact, a VA physician, instead of writing accurate notes for a given patient, was confirmed to have copied and pasted pulmonologist notes to 1,241 separate records, yet, astonishingly, he still works for VA.

Explain to this committee how that can be.

Dr. TUCHSCHMIDT. So, I don't want to go into a lot of detail in these cases tonight for a number of reasons. There are ongoing investigations in a number of areas around the country by the OMI, by other entities, law enforcement entities. There are potential issues around privacy and the rights of both employees and patients here. And most of these issues are very complicated issues, and I think we would be better discussing those in a brief with you, and I'm happy to do that.

The CHAIRMAN. Well, it may be better for you, but it's not better for this committee.

Dr. TUCHSCHMIDT. I understand.

The CHAIRMAN. I haven't identified anybody by name; we haven't divulged any patient names. Do you accept the fact that OSC says that, in fact, they found where a pulmonologist did, in fact, do this?

Dr. TUCHSCHMIDT. Absolutely. I don't dispute that. So——

The CHAIRMAN. Okay. So the question is, how in the world can this person still be employed at the VA?

Dr. TUCHSCHMIDT. So, as I said, I don't feel like I can really go into the details, but I would say this to you, and that is that I think that we very much are interested in the quality of care within VA. That documentation is an important part of that.

It is a common practice to take historical information from prior notes and use that information; that doesn't change. But we don't copy and paste material from other—from old records into new records as evidence of the current encounter with a patient. We would not tolerate that, we would not support that in the organization. That would clearly represent inferior patient care.

The CHAIRMAN. Ms. Lerner, could you comment on what's going on? You may not share the same fear that Dr. Tuchschmidt shares tonight of discussing something that may, in fact, be a source of the VA investigation.

Ms. LERNER. The theme that we see is that there is an investigation by the Office of Medical Inspector; the OMI confirms the whistleblower's allegations but then says it's not a problem.

So here in Montgomery, Alabama, the whistleblower said this is happening with a doctor who—a surgeon who discovered that another physician was cutting and pasting patient records. And these are things like vital signs, treatment plans—really important information for the surgeon to have before he operates on someone. He discovered that this physician was cutting and pasting. An OMI investigation substantiated it and, in fact, substantiated that it was over 1,200 patient records that were involved.

The problem is they put that physician on sort of a review plan. There's a specific name for it, FPPE, and I'm forgetting what all that stands for. But they did a review. While he was on that review, he still was cutting and pasting. And instead of them taking disciplinary action against the physician, they ended the FPPE—I think that's right, FPPE—and, as far as we know, no serious disciplinary action was taken.

So this fits the pattern that we're concerned about, where allegations are confirmed, no harm is found to patient health, and no corrective action is taken against wrongdoers. And that's really what I think needs to be fixed.

The CHAIRMAN. Who's luckier, the doctor that cut-and-pasted or the veterans that didn't get harmed by the egregious incident that the doctor, in fact, perpetrated on the patients?

Dr. TUCHSCHMIDT. Well, so, I think—I can't answer that question, but what I can say to you is that I think that, again, the cutting and pasting of information, if that particularly misrepresents things, would not be acceptable. It's not acceptable to us. And I'm happy to come and discuss those details.

There is this issue of harm. And when the OMI does their briefing and puts out their reports and says that they found no harm, I think that—I mean, I've looked at some of these cases, clearly. And I think that, while there might not have been evidence that someone actually was harmed by the process, I don't think that means that we, as an agency, would say that what happened was appropriate. I think those are different things, in terms of the OMI's work that they did of saying our review could not disclose that someone was actually harmed by that. But I want to reiterate that I do not believe that that—I don't personally interpret that, and I don't think our agency does, as necessarily condoning appropriate behavior.

The CHAIRMAN. But I would submit to you, before I yield to Mr. Michaud, that, in fact, by this person still being employed at the Department of Veterans Affairs, it does give the signal that it is an appropriate thing to do.

Dr. TUCHSCHMIDT. I understand.

The CHAIRMAN. Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Doctor, according to the VA's press release that today Acting Secretary Gibson has announced a restructuring of the Office of Medical Inspector in order to create a strong internal audit function which will ensure that issues of care, quality and patient safety remains in the forefront. What do you believe is the primary mission of OMI, what it should be?

Dr. TUCHSCHMIDT. Well, the OMI was set up really as a quality-improvement process within the organization. I think that it is clear, particularly with respect to the OSC cases, they were done prior to this in a different way. When the OMI took over them, the quality of those reviews improved tremendously. I think everybody agreed to that. The OMI did it at the request of OSC.

Today I think we realize that we need a different function within the organization, and that is really this kind of internal quality-control audit function that has been proposed. Today I can tell you that the OMI calls are going to the OIG. The OMI is not taking new cases in this interim period. And all of the issues, whether they come from OSC, or the OIG, or law enforcement or wherever they might come from, whistleblowers, are now being handled by a team of people at the Department level that report directly to the Secretary.

So I think that the organization is trying desperately to address the issues that are there with respect to doing these investigations, and the Secretary has made it very clear that not only will we expedite those investigations, but that, where appropriate, we will expeditiously take disciplinary action and hold people accountable.

Mr. MICHAUD. How many more employees does the Department plan to add to create this strong internal audit function?

Dr. TUCHSCHMIDT. I do not believe at this time that the plans for that—I know; it's not that I don't believe—I know the plans for that have actually not been entirely formulated, so I don't really have an answer to that question.

Mr. MICHAUD. Thank you.

Ms. Lerner, in your opinion, does the press release by the Department today vowing to restructure the Office of Medical Inspec-

tor address the issues that you have raised time and again regarding VA responses to complaints that your office has forwarded?

Ms. LERNER. That's a tough question to answer because we don't really know what the restructuring is going to look like. I am encouraged by the VA's sort of new response to this issue. I'm encouraged by statements that have been made to me personally by the Acting Secretary and by other leaders at the VA. You know, I'm an optimist. I think that it is very possible to make improvements and solve this problem. So I don't know the answer to your question. I think time will tell.

Mr. MICHAUD. This is for the VA: How would the VA ensure the recommendations and results of investigations undertaken by OMI are acted upon?

Dr. TUCHSCHMIDT. So we have for a long time taken the recommendations, the findings of the OMI. We ask facilities to develop plans of corrective action, and they have those plans, and those plans are tracked.

I think that one of the things that we need to do going forward in this new process is clearly to tighten up those various steps of the process from discovery, investigation, to action planning and accountability in a much tighter way. Those have been, up to now, really distributed over different silos within the organization. And, you know, in any system like that, that's prone for things to fall through the cracks, et cetera. So I think part of this process is really beginning to tighten those things up and draw a clear line through them.

Mr. MICHAUD. And following up on Chairman Miller's point, how will OMI achieve real accountability?

Dr. TUCHSCHMIDT. So I think the OMI itself—I don't know that the OMI will ultimately be doing this work, but the OMI itself probably will not be responsible for the accountability part, right? So that's a management function that requires its own set of activities to be able to do the fact finding, to look at the evidence and say, this is an appropriate disciplinary process. That needs to happen swiftly and systemically, but also with fairness.

Mr. MICHAUD. Thank you.

The CHAIRMAN. Mr. Lamborn, you're recognized for 5 minutes.

Mr. LAMBORN. Thank you, Mr. Chairman.

Ms. Lerner, you heard my questions to Dr. Mitchell and her responses. Veterans' health and safety, at least in Phoenix, was compromised because her warnings as a whistleblower were not heeded even to the point of patients dying, according to what she said. And as thanks for her efforts, she was retaliated against, to make it even worse.

How can we strengthen the whistleblower statutes that are already on the books to better protect whistleblowers like Dr. Mitchell in the future?

Ms. LERNER. You know, the Whistleblower Protection Enhancement Act, I think, has all the elements that are necessary to protect whistleblowers. It has to be enforced. People need to feel comfortable coming forward. The employer needs to create a welcoming environment for whistleblowers, and then welcome change that whistleblowers recommend and not ignore it, not minimize it.

Our agency, you know, enforces the Whistleblower Protection Act. And I think it's a good act. I think the structure is in place now for whistleblowers to be protected. I think robust enforcement is really important. I'm not positive what changes I would recommend making to the act to provide more protection.

Mr. LAMBORN. Well, then, if it's not working as well as it was intended to work, and you just said it needs to be better enforced, what has to change in the culture of the VA to prevent these problems from happening in the future?

Ms. LERNER. One step that can happen is the VA can become certified under the Section 2302(c) certification program. It's a pretty simple program that our agency helps to implement. I have gotten a commitment from Acting Secretary Gibson to have the VA become certified under that program. It's things that require more training for new employees, training for existing employees, having posters put up in the facilities, having a link to my agency's Web site on their Web site. Pretty simple steps, but it's a good first step for the VA to take.

I think another really important step is for the VA to actually take some expedited actions once retaliation cases are before us, and if we are working with them, to try and resolve them. Not having to go through a prolonged investigation and getting relief quickly to whistleblowers will send a very positive message. It would put some meat on the bones of the promise not to tolerate retaliation. So I'm very hopeful that will happen, and if it does, I think that will be a positive step.

There are other things that agencies do when they have a problem with culture of retaliation. We have worked with many agencies since I became Special Counsel 3 years ago. One that comes to mind very easily is the Air Force, where we got very serious complaints about retaliation at the mortuary when there were allegations about lost body parts and misconduct happening up in Dover, and we heard repeatedly from whistleblowers that the culture there was very, very bad. And once the Air Force decided to take steps to improve things and change the leadership and sent a strong message to its employees, we got reports back that things were much, much better.

So I don't think that this is an insurmountable problem, but because the VA is so big, it's going to really require a lot of effort to train supervisors at the regional level in how important it is not to retaliate when people come forward, and how to value the information that we're getting from whistleblowers.

Mr. LAMBORN. Well, if you want to weigh into this, there's legislation at least that the House has passed making it easier to fire certain people, the top 400 or so people in the VA. To me, that would send a very powerful signal, even if it's just the threat of that being available.

Ms. LERNER. That's possible. I haven't reviewed that legislation. I don't really feel comfortable commenting on it. But I will tell you, I think that it doesn't require firing. What we're seeing is not even sort of minimal disciplinary action. I'd like to see, you know——

Mr. LAMBORN. Anything. Anything at all.

Ms. LERNER.—at least some disciplinary action. I am not sure it requires termination, although in some cases it probably does. But

I think, again, there's probably a structure in place that would provide for that type of disciplinary action; we just haven't been seeing a lot of it. I'm not sure if new legislation is really necessary rather than just enforcement of the law as it exists today.

Mr. LAMBORN. Okay. Thank you very much.

Mr. Chairman, I yield back.

Mr. BILIRAKIS [presiding]. Thank you.

Mr. TAKANO, you're recognized for 5 minutes.

Mr. TAKANO. Thank you, Mr. Chairman.

Ms. Lerner, so are you saying that the current civil service protections are not so onerous for managers to be able to impose progressive discipline, discipline dismissals in this case that we have cited today about the doctor copying and pasting medical records?

Ms. LERNER. You can be terminated for misconduct under the Federal civil service laws for sure.

Mr. TAKANO. And there's a current——

Ms. LERNER. There's a current framework for doing that.

Mr. TAKANO. You are saying, for whatever reason, it's just not happening at the VA. Do you have any—can you speculate as to why it's not? Is it because managers aren't adequately trained? I mean, it's quite extraordinary for a colleague to turn on another colleague, so it points to a management abandonment here in this instance.

Ms. LERNER. We do have at least one case I know of where the VA has taken disciplinary action in a retaliation case. It's not impossible to do it at all; there just has to be a willingness to do it. What we have seen for the most part in our cases is that people are not really disciplined, or if they are, it's a very mild discipline. What is going on at the VA in terms of why they are not doing that, I really can't say, but it is certainly possible, and we have seen it done.

Mr. TAKANO. I'm just curious, Dr. Tuchschmidt, this case of this particular physician copying and pasting, I've generally heard positive reviews of VistA by VA doctors. Some people outside the VA tell me that the—it's not—it's incredibly user friendly; that there can be pages and pages, and finding relevant data is difficult.

One doctor I spoke to recently, who is retired from private practice, now evaluates records for the courts for the purposes of determining whether people are eligible for SSI disability. He reviews lots of veterans records, and he says he'll get a record from the VA that will be like a phone book, whereas other record systems in the private sector, much, much thinner, and he has to go through pages and pages and pages to be able to get the relevant information.

Is there some truth to this? And is part of the reason why this doctor was able to maybe think that he could get away with this is some vulnerability in the VistA system?

Dr. TUCHSCHMIDT. Well, so when you print out charts, they may be very thick. Our patients tend to have multiple complex diseases, have a lot of visits in the organization. They're sicker than the average private patient.

I think that the computerized patient records system—so without going into the specifics of this case, I can talk a little bit about what is common practice. So that if I am seeing a patient, and I

need to put into that record the patient's problem list, the things that are wrong with them, a list of things that are wrong with them, their past medical history about when they had surgery or when they were hospitalized in the past, those facts don't change.

So it is common practice on paper to go look at the chart and rewrite those things on a new note, or, in an electronic record system, to copy that section and paste it. If someone is not careful, they may capture more than they intend to and inadvertently place it in a new note. I'm not saying that's what happened here. I'm actually not defending what happened in this situation; I'm just trying to explain a common practice in what could happen.

You know, I want to say a couple things, and that is that I think that we have many elements of the whistleblower certification program in place. We have training. We've had training for a long time. I think the Secretary has made a commitment to have that. We've had some discussions about that, and, you know, we want to do that.

I think that accountability, we heard a lot tonight about culture. You know, you can change structure and processes and people. In the end it's about leadership, and it's about accountability in the organization, and I think that's the commitment that Secretary Gibson has made. It's a commitment I'm making tonight.

And I would say I think one of the biggest issues that I heard tonight was people who felt like they suffered while the process was being resolved. And I would make a commitment tonight: I'll give you my cell phone number, and you can call me, and I will do whatever I can to intervene the moment you know so that those employees do not suffer adverse consequences while you do your investigations.

Ms. LERNER. Thank you. You're the second person who's given me their cell phone number for that very reason. So, you know, I am getting that message. I am encouraged.

Mr. TAKANO. Mr. Chairman, my time has expired.

The CHAIRMAN [presiding]. He didn't say he would answer his cell phone.

Dr. Roe, you're recognized for 5 minutes—excuse me, Mr. Vice Chairman, Mr. Bilirakis, you're recognized for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it.

Dr. Tuchschmidt, how many employees have been placed on administrative leave, reprimanded or terminated thus far in connection to falsifying or negligence which negatively affects a veteran and the health care they receive through the VA?

Dr. TUCHSCHMIDT. I can't give you a number tonight, sir. I can tell you that we have in some of these—specifically some of the cases cited looked at those action plans, and where there was administrative action recommended, we have taken administrative action in those cases. I am not prepared tonight to actually——

Mr. BILIRAKIS. You can't give me a rough estimate over the past year?

Dr. TUCHSCHMIDT. I can't. I don't have that.

Mr. BILIRAKIS. Can you get that information to me as soon as possible?

Dr. TUCHSCHMIDT. I can take it for the record, and we can get that to you.

Mr. BILIRAKIS. All right. Thank you.

Mr. BILIRAKIS. How many employees have been placed on administrative leave, reprimanded or terminated for actively retaliating against whistleblowers?

Dr. TUCHSCHMIDT. Again, I would have to take that for the record.

Mr. BILIRAKIS. I would like to get that information as soon as possible.

Dr. TUCHSCHMIDT. Sure. Absolutely.

Mr. BILIRAKIS. Thank you.

Mr. BILIRAKIS. Ms. Lerner, how many whistleblowers have been placed on administrative leave, reprimanded or terminated for attempting to expose misconduct within the department? Can you give me a rough estimate if you don't have that information at this time?

Ms. LERNER. I don't actually have that information. I can tell you that we have complaints from 67 whistleblowers right now that are active in our agency. I'm going to turn to my deputy Mr. Bachman and see if he can add to that.

Mr. BILIRAKIS. Okay.

Mr. BACHMAN. Thank you.

Yes. I don't know that we have a specific number. We do, however, have at least three whistleblowers from the VA who have come forward recently that OSC has been able to get stays of pending disciplinary action against them. For example, they come forward and are almost immediately hit with the 14-day suspension, a 7-day suspension. We have contacted the VA and persuaded them to stay those actions while OSC conducts its investigation. So that's one role that OSC is able to play in all this.

I would be happy, though, to go back and check our records and see if we can find exact numbers for you in terms of administrative leave or even other disciplinary actions.

Mr. BILIRAKIS. Yeah. Would you say that there are more whistleblowers who are being reprimanded per se as opposed to those who have misconduct and negligence in treating our veterans?

Mr. Bachman. If what you are asking is do the whistleblowers who come to us suffer adverse consequences and——

Mr. BILIRAKIS. Adverse consequences more so than maybe someone who has committed negligence or malpractice on a veteran?

Mr. Bachman. Unfortunately, I just don't know the goings on of those negligence or malpractice cases.

Mr. BILIRAKIS. Anyone on the panel know the answer to that question?

Dr. TUCHSCHMIDT. No, I don't think I could answer that question.

Mr. BILIRAKIS. Okay. I'd like to get that information as soon as possible, please.

When cases are referred to the OSC, and claims of misconduct have been substantiated, what disciplinary action is taken? Anyone? Ms. Lerner.

Ms. LERNER. Sure. One of the things that we look for when we get the agency's report of investigation is what disciplinary action, if any, has been taken. And I would say in most of the cases that we have reviewed, there has not been disciplinary action taken. I

can't give you exact numbers, but I can tell you that it is the exception and not the rule.

Mr. BILIRAKIS. Okay. One last question. Dr. Tuchschmidt: What consequences will those who provide false information to the OIG face?

Dr. TUCHSCHMIDT. Well, I don't know that I can answer that question specifically, but I can tell you that when we do believe that disciplinary action needs to be taken, there is a set of criteria that depend on the egregiousness of the, you know——

Mr. BILIRAKIS. Give me a hypothetical case.

Dr. TUCHSCHMIDT. Well, so I'm not sure I'm going to be able to make up a hypothetical case. So there is a table of penalties that exists, and that is both judged by what has happened before, because the intention of disciplinary action is not to, you know, be punitive, it is intended to try and change the behavior of the employee. Where we feel that we can't change that behavior, it's a hopeless situation, obviously separation is what has to happen. But usually that's the end result of a series of processes to try and remediate the situation.

Mr. BILIRAKIS. So if they give false information to the OIG——

Dr. TUCHSCHMIDT. That would be criminal, I would think.

Mr. BILIRAKIS. Okay. All right. Thank you very much.

I yield back, Mr. Chairman. And I would like to have that information as soon as possible, the answers to those questions. Please. Thank you.

Dr. TUCHSCHMIDT. Yes, we'll get you what we can.

The CHAIRMAN. Ms. Brownley, you're recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chair.

Ms. Lerner, you spoke about the whistleblower program and certification as being a good first step. So can you tell me why the certification program is an optional one, and why it's not mandatory?

Ms. LERNER. Now it is mandatory. Recently the President and Office of Management and Budget issued an order requiring agencies to go through that certification process, and their plans for doing so were supposed to have been posted by June of this year. I don't know why it was initially made a voluntary program. We started this certification program, I believe, in the early 90s, and unfortunately not a lot of agencies have been certified.

Ms. BROWNLEY. So did the VA comply with that by the deadline of June, or are they saying now they are going to go through the steps for certification?

Ms. LERNER. I don't know if their plan has been posted. I don't think it has, but I was told last week by the Acting Secretary that they would be doing so very soon. So I'm going to try and follow up.

Ms. BROWNLEY. Trust and verify.

Ms. LERNER. We'll verify for sure, and our agency will help them become certified. In fact, I sign a little certificate for every agency that becomes certified, so I will know the minute that they reach that milestone.

Ms. BROWNLEY. Very good.

And we heard from our panelists earlier today whose identities were compromised in the process of working with the IG and one panelist with the White House. You heard the testimony. So can

you give me an idea of what your office does, what the IG's office, what steps are taken to ensure protection of a whistleblower?

Ms. LERNER. Sure. If someone comes to us with a disclosure, they have the option of remaining anonymous. If they choose not to remain anonymous, when we refer it to the agency for investigation—and let me just make it clear, we don't do independent investigations for disclosures. Once we make a finding of a substantial likelihood, it's a high burden, we then send it to the agency for investigation. We then review the agency's investigation for reasonableness and then report to the President and the oversight committees in Congress.

So the first step on keeping information confidential is asking the whistleblower if they want to remain anonymous. The second is that when we refer a matter for investigation to an agency, we remind them of the need to protect the whistleblower. If they are choosing not to remain anonymous, we remind them that they have to protect that person from retaliation.

In order to do a full investigation, though, sometimes you have to actually speak to the whistleblower. One problem that we have found is that often in the investigations, the IG or OMI doesn't actually talk very thoroughly to the whistleblower, and sometimes they don't even interview them. And that's a problem in and of itself because the whistleblower is really a subject matter expert, and they have to speak to the whistleblower to really get the full picture. So it's very hard to, you know, do an investigation without disclosing identity.

Ms. BROWNLEY. Will part of the certification program, though, help with enforcement in terms of the protection piece?

Ms. LERNER. The certification program in itself doesn't directly involve enforcement, but by making sure that supervisors are trained and informed and knowledgeable about their responsibilities when someone does come forward, and reminding them that retaliation in all forms is unlawful, I do think that it would have the derivative effect of serving that purpose.

Ms. BROWNLEY. Thank you.

And, Dr. Tuchschmidt, so I understand you're relatively new to this position?

Dr. TUCHSCHMIDT. Yes, I am.

Ms. BROWNLEY. And you were formally with the VHA and their transformation efforts?

Dr. TUCHSCHMIDT. Yes.

Ms. BROWNLEY. So I presume that means the VA's transformation. And so I'm just curious to know from in your old position, you know, how you thought you were doing vis-α-vis the transformation of VHA, and did you know of any of the things that have been discovered over the last few months in this committee? Were you aware of any of those things?

Dr. TUCHSCHMIDT. No, I don't think—I was not aware. I think most people in the organization at senior levels were unaware, which I think is actually part of the problem. I think that—you know, I mean, my job as transformation lead for the organization, we implemented our PACT program, we expanded our telehealth program. Those are the things that I was working on. I can tell you

before that I was a medical center director for 12 years, so I have, you know, a lot of operational experience.

I think, just to add on to her point, you know, I think that training and education is really important, right? People have to know what the right standard of conduct is. And then second point I would make is that once they know, it makes it a lot easier for us to hold people accountable. I mean, you can't say, I didn't know, you know, those rules anymore. So I think that program actually has the potential to have a pretty positive impact.

Ms. BROWNLEY. Thank you. I yield back.

The CHAIRMAN. Dr. Roe, you're recognized for 5 minutes.

Mr. ROE. I thank the chairman.

Dr. Tuchschmidt, we do a lot of things to patients, as you know——

Dr. TUCHSCHMIDT. Yes, we do.

Mr. ROE [continuing]. That require one thing that is very important, and that is called trust. And, you know, you've said the VA was great, and I want it to be that. I have a VA a mile from my home, and a lot of good people tomorrow are going to get up and go to work at the VA and try to take the very best care of patients they can. But through all of this investigation, we've lost trust in the VA. How can we trust anything the VA says when we have panel after panel that come explain, tell us these egregious things that have occurred?

And let me just give you an example. It's almost impossible to make a politician speechless, but the VA has done that. And Brockton, Massachusetts, when you have two severely mentally ill veterans in the hospital, and, listen to this, a second veteran was admitted to the facility in 2003 with significant and chronic mental health issues, yet his first comprehensive psychiatric evaluation did not occur until 2011, how in the world in a healthcare system in America could that happen anywhere?

And let me go on. No medication assessments or modifications occurred until 2011 when another doctor came along and reevaluated this veteran. Despite these findings, the OMI would not acknowledge that the confirmed neglect of residents at the facility had any impact on patient care. The VA's typical answer is a harmless error approached concluding the OMI feels that in some areas the veterans could have been better taken care of—yeah, not like ignored for 8 years—but the OMI does not feel their patients' rights were violated. How in the world with a straight face can you do that?

And then back to the chairman just a moment ago with this person pasting and cutting and all that, that is someone who is dishonest. And me, when I have a consultant, and I've been to the operating room thousands of times, I have got to know what they're telling me is truthful. And I can promise you this: If that had occurred in my practice, they would have been fired on the spot. If we found that out in our hospital where I practiced for over 30 years, they would have been fired on the spot.

And what we are hearing is is that the people, the whistleblowers who bring this up, as Mr. Bilirakis just said, suffer more consequences than the people who actually did the egregious act. I don't understand that at all. Can you enlighten me a little bit?

Dr. TUCHSCHMIDT. Well, quite frankly, I'm speechless. I mean, I'm appalled. I mean, I don't know what else to say. I think that—and Dr. Huycke may have some comments about the OMI process that he'd like to make, but I can tell you that I don't think any of us think that that's acceptable for a patient to be in one of our facilities for 8 years and not have a major psychiatric exam except once. I can't defend that.

Mr. ROE. It is beyond comprehension to me that not one but two veterans were at that facility. And I know you said this a moment ago, but we have—the OIG brings information up here. If someone knowingly lies to the OIG, you shouldn't have to go any further. You're dealing with a liar. You shouldn't have to go any further other than you're out of here today. Don't go by the cash register and pick up your check. You're fired.

Dr. TUCHSCHMIDT. Yep.

Mr. ROE. And right now it doesn't appear the VA is doing that. We tap dance around all these things.

Let me just ask one other question very quickly. My time is about up, also. Basically how can you—and I know you're new in this position—undo the damage you've done to physicians and others whose careers have been damaged by this? What do you do to repair their reputations?

Dr. TUCHSCHMIDT. I don't know the answer to that. You know, in some cases the damage clearly has been done. I don't know. But, you know, I think that we clearly owe some people an apology. I think that we need to figure out how, where we can, make people whole. I think we try to do that. But, you know, I think the most important thing is that we have to go forward. I can't undo the past, but I can do something to change the future.

Mr. ROE. I appreciate that, and, as I said, I feel very badly for the people who are going to go to work tomorrow for the VA who are doing a good job. They're working hard. And let me tell you who needs an apology: the two veterans who are mentally ill and their families who they were completely ignored, and the 1,241 people that had something done to them at the VA. You have a reasonable expectation when you're in a hospital that people are being honest.

I mean, I handed off cases at night when we would turn over the duty, and you'd take the beeper—now it's a cell phone—take the beeper. You expected your partner to tell you the truth because people's lives depended on it. This is not some game we're playing.

Dr. TUCHSCHMIDT. Absolutely.

Mr. ROE. These people's lives are at stake.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you.

Mrs. Kirkpatrick, you're recognized for 5 minutes.

Mrs. KIRKPATRICK. I appreciate what Acting Secretary Sloan Gibson is doing with restructuring the OMI and coming up with a strong internal audit system; however, I must express that I am skeptical about how that's going to work. Ms. Lerner testified that we have the Whistleblower Protection Act, but it's not enforced. And so my concern, first of all, is that we've heard so much testimony in this committee about a culture of secrecy, about a culture

of retaliation, and retaliation is a huge deterrent to hearing complaints.

So my first question, Ms. Lerner, is to you. We've heard that there's been retaliation against employees. I'm concerned that there is retaliation against patients who might feel that they have a complaint against a facility. Are you aware of any retaliation against patients, against veterans?

Ms. LERNER. I think that's a really important question, and I don't know the answer to it. I'm not aware of any retaliation, in part because my agency's jurisdiction is just for employees to come forward with retaliation complaints or disclosures of waste, fraud or abuse, or health or safety problems. Someone could come to us with a disclosure if they thought that a patient, you know, was being retaliated against. I don't believe we've gotten any of those cases.

People do come to my agency with disclosures about poor patient care, where they complain about patients not getting appropriate treatment and then are retaliated against themselves for having made those complaints. But in terms of patients, we probably wouldn't get those.

Mrs. KIRKPATRICK. Is there some kind of national hotline that VA patients can call if they have a complaint about a facility?

Ms. LERNER. I don't know the answer to that.

Mrs. KIRKPATRICK. Doctor, do you know?

Dr. TUCHSCHMIDT. So there are a number of mechanisms that patients now have to give us feedback about their system. They complain, quite frankly, do complain directly to our patient advocate system. That is a real human being sitting at each facility that they can go to.

Mrs. KIRKPATRICK. That's my concern: at each facility. So you see, what we're seeing here is this pattern that, yeah, the complaint stays within the facility. It never goes outside of that.

Dr. TUCHSCHMIDT. Yes.

Mrs. KIRKPATRICK. And let me just throw out an idea. You know, I'm a former prosecutor, and we used to have a really difficult time getting people to report child abuse and neglect, elder abuse until we established a hotline where the reports could be anonymous, but there would be an investigation, and then we started to be able to get these reports. There was absolutely no possibility of retaliation any way, anywhere because of those reports, even if they turned out to be false.

And I just don't see how we're going to be able to get to the root of this without something like that in place where there's a hotline that veterans can call if they feel like that they didn't get the care they wanted, and that employees can call and make reports so that there's absolutely no possibility of retaliation. Would you consider something like that?

Dr. TUCHSCHMIDT. Yeah. So in addition to the local options that veterans have, veterans can—patients can call the OIG hot line today, and we are——

Mrs. KIRKPATRICK. But who knows that? Who knows that? Who knows how to do that? Do you get my point? I mean, we're really going to have to look at this very hard, you know, and really put our veterans first.

Dr. TUCHSCHMIDT. Absolutely.

Mrs. KIRKPATRICK. The employees are taking care of them first. I'm sorry to interrupt you, but I feel very passionate about this.

Dr. TUCHSCHMIDT. I do, and I respect that tremendously. You know, so I think that one of the things that we are looking at today, so the Department of Defense has a program that they call ICE. It is an interactive thing on their Web site. Actually any patient, any employee can go right on that Web site and provide feedback, file a complaint, say you did a great job, and it goes right up to the top of the command chain. We are looking at that. It'd be free to us to bring it over into the VA, to be able to put it on our Web site.

Right now we are in discussions about what's the mechanism, you know, what's the business processes behind that. And, quite frankly, I will take your point that you're making tonight back home and say it needs to be high in the organization.

Mrs. KIRKPATRICK. Thank you. Thank you very much.

I yield back the balance of my time, Mr. Chairman.

The CHAIRMAN. Mr. Flores, you're recognized for 5 minutes.

Mr. FLORES. Thank you, Mr. Chairman.

Ms. Lerner, it's our understanding the OCS is spending a substantial amount of its time on these whistleblower—on the caseload from the whistleblowers. Can you tell us what Congress can do to help alleviate the amount of time that you're having to spend on that activity so that you can continue to take care of the needs of the VA whistleblowers?

Ms. LERNER. Well, I want to maybe start by answering the question by noting that this committee has been particularly supportive of our work. I want to recognize the staff of the Oversight and Investigation Subcommittee for their work on this issue and their work with our agency. We consider it to be a real partnership, and we are very grateful for this committee's support. We've also received a number of referrals from this committee, and we appreciate your confidence in our ability to work with the employees that your office refers. So that's one thing that's already happening.

We are doing everything that we possibly can to address VA cases quickly and thoroughly. We've set up a priority intake system for VA cases. We've reallocated staff to handle VA employee claims. But as the numbers increase, it's very hard to keep up. We were at capacity before the VA cases kind of overtook us, and the total number of cases between disclosures and retaliation cases now exceeds 130, and the number, as I mentioned, continues to increase pretty much daily.

Mr. FLORES. Wow.

Ms. LERNER. We're a tiny agency. We have 120 employees, more or less. We have jurisdiction for four statutes: the Hatch Act, the Uniformed Services Employment and Reemployment Rights Act, and we are working now on the demonstration project that this committee provided to us. We also handle disclosures, over 1,200 a year, and this year will be a record with the VA disclosures. And we also handle prohibited personnel practices. So we're stretched pretty thin right now.

Mr. FLORES. Well, please continue to let us know what we could do to be helpful so that we can sort through your current workload

as well as the new VA workload that you're having to deal with now.

Ms. LERNER. Thank you.

Mr. Flores. Dr. Tuchschmidt, one of the things we've talked about is that some whistleblowers have provided some limited patient information which is allowed through special channels to deal with what they perceive as problems at the VA. When they do this, it is not a violation of HIPAA, but yet these employees are being charged with privacy violations. What can we do about this? How do we get the VA to stop the charges of privacy violations when the whistleblowers go through the proper steps to do this?

Dr. TUCHSCHMIDT. So I am aware of one instance where that happened, and an employee, in my opinion inappropriately, was put on administrative leave while that investigation was being done over concerns that the person took patient information and did violate HIPAA. I can tell you that the leadership at that facility now knows that people, whistleblowers have a right to have information, can share that information with the OSC, the OIG, with Congress, and it is not a HIPAA violation.

We need to do a better job of making sure people across our organization understand this issue clearly. And, you know, I wish I could say it will never happen again. I think that would certainly be our intention to make sure that people are more aware and more cautious about what they do.

Mr. FLORES. Okay. We will continue to try to put that message out.

I yield back.

The CHAIRMAN. Ms. Kuster, 5 minutes.

Ms. KUSTER. Thank you very much, Mr. Chairman, and thank you to all of you for coming this evening.

I wanted to ask Dr. Tuchschmidt, in the private sector in hospitals, they have a process of quality assurance, typically a quality assurance committee where information that is shared in reviewing cases with that committee is typically by statute protected from discovery in a medical malpractice lawsuit.

And as an attorney, I want to get to the bottom of whether part of the behavior that we're hearing about tonight and throughout the testimony from the whistleblowers has to do with people within the VA trying to protect the agency from medical malpractice lawsuits; and, if that's the case, is there something that we could do statutorily?

This is something that I'd worked on at the State level many, many years ago is a statute that protected quality assurance so that you can have a quality-improvement process going forward without all this behavior of covering their backs and, you know, blaming people that are bringing these issues forward. Could you comment on that?

Dr. TUCHSCHMIDT. So I think we have, quite frankly, adequate protections in place for quality assurance documents that are covered statutorily, right? I can't say—I mean, we're an organization of 300,000 people, right? I don't know what everybody thinks when they go out and do something, but I can tell you that I don't—I'd be surprised if a concern about the release of quality information

is part of what might be motivating some of the concerns and particularly the retaliatory behavior about whistleblowers.

You know, I think clearly managing those situations is difficult for local management. I think we need clearly to do a better job of informing and educating. I mean, again, I don't know how to say it any better. I mean, I was appalled by the stories I heard tonight. I don't think we as an organization should tolerate that. I don't think you should let us tolerate that.

Ms. KUSTER. Trust me, we're shocked.

Dr. TUCHSCHMIDT. I'm shocked. I'm shocked.

Ms. KUSTER. Well, I just wanted to get to that issue.

On another issue entirely, another level of shock for me was the information in the record that we have about Dr. Head and the very clear pattern, disturbing pattern, of racial prejudice. Can you tell me, within the organization, first off, how does that exist in this day and age? But second off, is there some way to cope with that and make sure that that's not—you know, in this day and age, honestly, with the progress that we've made in our country in all aspects of diversity, gender, race, religion, ethic background, I can't imagine with this many employees that it could even begin to be tolerated, the type of behavior that is documented here in this lawsuit. It's extraordinary.

Dr. TUCHSCHMIDT. Well, I mean, I was absolutely floored. I was floored when he held up his picture tonight, and I know what was in his other slide, and it's even more abhorrent. And it's astounding that it happened at the UCLA medical school amongst highly educated professionals. I don't get it. I mean, I just don't get it. You know, again, in an organization with 300,000 people, people do stupid things, right, and we can't always control that.

Ms. KUSTER. But would there be a procedure, would there be any kind of protocol or process if that was reported up the chain?

Dr. TUCHSCHMIDT. Absolutely. And, you know, in my 20-something years, I can tell you, I think that this organization has been for a long time one of the most inclusive and supportive of diversity organization I have seen. I mean, we train people. We train people on EEO and workplace harassment issues. We have programs to support cultural diversity and cultural competency within the organization. You know, I'm astounded, quite frankly, by Dr. Head's story. Quite frankly, I learned about three of these four whistleblowers the first time by reading about it in the paper.

So I think that, you know, we clearly need to do a better job of making sure that people can communicate their concerns. There are a lot of avenues, right? I mean, they have the OSC process. They have the OIG. They can come to you all. But my dismay is that they don't feel like they can come to us within the organization, because that's where it has to start.

If we really want an organization that is dedicated to safety, to quality, to integrity, it has to start with our employees on being engaged on the frontline, and taking a meaningful role, and feeling like they can fix those things that are within their sphere of influence and go to people that can when they can't. And if we can't do that, we will fail.

Ms. KUSTER. My time is up, but we all concur that that's what we need to do. And as far as I'm concerned, there are people that need to lose their positions over this.

So thank you, and I apologize, Mr. Chairman.

Dr. TUCHSCHMIDT. Thank you for letting me go over.

The CHAIRMAN. Dr. Benishek, you're recognized for 5 minutes.

Mr. BENISHEK. Thank you, Mr. Chairman.

Ms. Lerner, Dr. Mitchell in the previous panel talked about what she thought was—explained was a sham peer review process. Have you seen anything like that in your investigations?

Ms. LERNER. I'm going to ask Mr. Bachman.

Mr. BACHMAN. We have seen that in some of our investigations and are taking a very close look at those when we see them. These types of investigations can be difficult to prove as pretext for retaliation sometimes, but we are seeing that as an emerging trend, and it's something that we are focusing on and making sure that we're gathering all the evidence we can to see exactly why was this peer review undertaken.

Mr. BENISHEK. All right. Thank you.

Dr. Tuchschmidt, are you aware of this VA program that was started on April 2013 called the "Stop the Line" patient safety initiative that Mr. Jolly talked about? Are you aware of that program?

Dr. TUCHSCHMIDT. Yes. So I'm not sure exactly I know which program you're talking about, because there are—you know, so Stop the Line is part of a lean technology, right, process. There are many——

Mr. BENISHEK. Well, as I understand, it's a way for current VA employees to step forward when they see something going on that they would expect a change in quality.

Dr. TUCHSCHMIDT. Absolutely. So many of our facilities have implemented lean on their own, but as part of our national patient safety program, we have a Stop the Line timeout process. So any employee—and this is particularly true in our procedure-based areas—any employee who feels like something is not right before something is about to happen to the patient can call a timeout, stop the line and say, I disagree with that. That could be the doctor; it could be the nurse; it could be the housekeeper in the operating room that stops the line because they feel that something isn't right, and the line stops until it's resolved. So that's part of our national patient safety.

Mr. BENISHEK. Does the VA keep track of how many times this initiative is invoked?

Dr. TUCHSCHMIDT. No, not to my knowledge.

Mr. BENISHEK. Are reports collected?

Dr. TUCHSCHMIDT. Not to my knowledge. It's part of the business process. It's not something——

Mr. BENISHEK. You know, I was just aware of this incident here where I've got a report of 60 Chiefs of Anesthesia within the VA around the country invoked a formal communication to the VA with this Stop the Line initiative regarding a policy that would change how surgical care was delivered. And the Chiefs' communication was sent to the VA Secretary, the Under Secretary for Health and the Principal Deputy Under Secretary for Health on October 1, 2013.

Dr. TUCHSCHMIDT. That would be the former Principal Deputy.

Mr. BENISHEK. Yeah, yeah, yeah, you're the acting, I understand. But despite being told otherwise by VA officials on as recently as June 17, the Chiefs of Anesthesia have informed me that they haven't received a response at the VA.

Dr. TUCHSCHMIDT. I'm unaware, I can't comment, but I'm happy to take that back and find out——

Mr. BENISHEK. We were briefed that they did get a response, and then subsequent to that we were told by them that they didn't. So I'd like to know what the response is, and if you didn't respond, could you please get that to me?

Dr. TUCHSCHMIDT. I have no idea, but I will get a response for you and for them if they didn't get one.

Mr. BENISHEK. Do you know how often the VA gets a letter from more than 60 Department heads about a problem?

Dr. TUCHSCHMIDT. I don't.

Mr. BENISHEK. It would seem like that would be worth a response to me.

Dr. TUCHSCHMIDT. It would seem atypical, yes.

Mr. BENISHEK. Well, there's so many atypical things, Doctor, that you're having to explain. And, actually, I really appreciate your apology to the veterans of this country. I felt your emotion when you first gave your statement.

Dr. TUCHSCHMIDT. Thank you.

Mr. BENISHEK. But you see what a huge problem we're trying to deal with here.

Dr. TUCHSCHMIDT. We have——

Mr. BENISHEK. I mean, you know, you yourself are expressing, you know, severe emotion, and it's hard for us to even sit here without going, what is going on, and how do we fix this. And you're in the same boat. And, you know, we need some real dramatic change here. And we're hoping—we're all hoping that this new Secretary and the legislation that we will work on will make a dramatic change within the VA, because, you know, I worked at the VA for 20 years, and I felt that. And with the comment you made earlier about these things being isolated incidents that these guys talked about, it's not. It's not isolated incidents. I mean, I went to the meeting of the VA physicians in Dennis, and there's like a whole mess of them are telling me this. So, you know, it is a systemic problem, and we need to deal with it.

Dr. TUCHSCHMIDT. I appreciate your sentiments.

Mr. BENISHEK. Anyway, I am out of time. Thanks.

The CHAIRMAN. Mr. Walz, you're recognized for 5 minutes.

Mr. WALZ. Thank you, Chairman.

I thank you all for being here.

And, Dr. Tuchschmidt, I agree. And as so often is the case, I concur with Dr. Roe. I think what's at heart here and maybe something it doesn't appear like to me people have come to grips with. Your feeling of being sick and disillusioned, that's how I feel. That's how my veterans feel. A generation of good work has been erased. I think you understand that.

Dr. TUCHSCHMIDT. Absolutely.

Mr. WALZ. Very, very difficult because this is about care. It's about getting the trust in them. It's about getting them into the

system. It's about working on things like seamless transition. It's about making sure programs for blinded veterans are there, all the things we've worked on. And I sat sitting here for 8 years and 24 years prior in uniform trying to prove to be a good actor on this or whatever. But the question I have is, again, what's going to change? What's your definition of "unacceptable"?

Dr. TUCHSCHMIDT. Well, I think, quite frankly, that the bottom line for me from the time I went to medical school until today has been has the patient gotten what he or she believes they needed? And it has to be quality; it has to be safe and effective. I mean, to me, that's the bottom line.

Mr. WALZ. The thing is we try and work around this and find what the fix is, because at the end of the day, we're going to sit here—and I agree, we have to diagnosis first before we can prescribe the treatment on this. We're going to have to commit, but we have to move forward on how to get it fixed.

So today the letter comes out on the restructuring of the Office of Medical Inspector. And it is very clear that the Acting Secretary made it clear, as I told our workforce, intimidation or retaliation against whistleblowers or against any employee who makes a suggestion or reports what may be a violation of law is absolutely unacceptable.

Was it not unacceptable to Secretary Shinseki? Was there any way in that man that you got the impression or your employees got the impression that it was acceptable then; it's not now?

Dr. TUCHSCHMIDT. That was never apparent to me.

Mr. WALZ. What changed? What changed today?

Dr. TUCHSCHMIDT. I think what has changed today is that we do have new leadership, right? I mean, so Acting Secretary Gibson has stepped up. He is out in the field going to medical centers. He has, in fact, pulled this process of whistleblower and investigations up to the Department level where he can personally supervise it. His engagement and commitment in this is phenomenal.

Mr. WALZ. One of the complaints about how the VA works and the insular nature of it is that there's a belief that they can just outlive people. They are going to outlive Mr. Gibson. And they might be thinking, we'll outlive this guy. November is coming around; he'll be gone. Secretaries will be gone, Presidents will be gone or whatever.

I have to tell you, and this pains me more than anything, this breach of faith—and I have sat up here for 8 years, and I'm your strongest supporter, but I'll be your harshest critic. I listened to this today, and it floors me that I don't believe with one fiber in my being that you're going to get this right, and that is disturbing, which makes me then come back and say, and if I were you sitting there asking what are you going to do about it, that's what I'm asking for. I want us to take back more of this, I want us to pull this back in, and I want to do the data and know that the data is true.

And so I ask you, Ms. Lerner, is there a way to do this? Is there a way to have the third-party validation, to have that accountability? I would argue we can be the most accountable people because we have to stand in front of voters that are the constituents and the veterans every 2 years. Those SES folks are never going to see my veterans, ever. So I ask you, how do we restructure this?

Are we trying to fix a broken system that is beyond repair on trying to get this accountability?

Ms. LERNER. Well, I said before, I'm an optimist.

Mr. WALZ. I am, too. I supervised a high school lunchroom for 20 years.

Ms. LERNER. And you're very brave as well.

Mr. WALZ. So I am the ultimate optimist, and I have been shaken by this. So that's why I ask you, what proof is there? Words or something. What proof is there to you? Your reputation is on the line now, too, if you say it's going to be fixed by this.

Ms. LERNER. Well, I don't know. I mean, my job is to shed light, because that's the best disinfectant on, you know, a broken system. And the whistleblowers are shedding light on where the problems are. The next step is to actually see some action.

Mr. WALZ. Correct.

Ms. LERNER. And what we've heard in the last several weeks from the new leadership I believe is encouraging, but it is going to have to be——

Mr. WALZ. Eight weeks ago I asked what is the problem with the Rochester VA, and higher people than you sat there and told me, you are right, Congressman, you deserve an answer right away. So here I said I'm off the reservation on this one. Why has there not been an answer on that? So how should I believe that? A Member of Congress was told they would get them an answer about what's wrong with their local VA, a place where I sat much time with my veterans, and I have not got an answer.

Ms. LERNER. I'm not here to defend the VA. I mean, I've had a pretty ringing indictment of what's been going on. But I think that there are steps that can be taken.

Expediting review of whistleblower complaints when people believe that they're being retaliated against, if we get can get that expedited review in place and whistleblowers can see quick action, that sends a very powerful message, not just to the individuals who are involved but to the facility. If there's disciplinary action when someone retaliates against someone, we need to have actions that back up the positive words.

Mr. WALZ. Yes.

Ms. LERNER. And we haven't——

Mr. WALZ. And you think we can get them, doing this new structure?

Ms. LERNER. I'm going to do my best to follow up on the promises that have been made to me. I expect this committee will join me in continuing to do oversight. That's our job. I am happy to come back here in 6 months and report back to you on what actions we've actually seen taken.

But one of the problems, I think, has been that we've gotten the warnings from the whistleblowers about where the problems are, but they have been sort of hidden from, I think, probably VA leadership because the OMI has been saying, no harm, no foul, you know, there's no violation here, there's no regulation that's been violated.

In Brockton, what we heard from the OMI——

Mr. WALZ. Why did you not suggest total elimination of the OMI?

Ms. LERNER. Well, whatever replaces the OMI is going to have the same issues. I think there are certain steps that can be taken, whether it's the OMI, whether it's the IG.

Whatever the entity is that is investigating, there needs to, number one, have a review triggered whenever there is a finding of a problem. It has to go higher than whatever the investigating entity is.

I think the second thing is there has to be a look to see whether actual harm has occurred. Because what we've been seeing is that the OMI says, yes, the allegations are true but there's no harm here, but they don't really look to see whether patients have been harmed or not.

In the Brockton case, the OMI only looked at the three patients that the psychiatrist reported on. The psychiatrist said, "I think this is probably a widespread problem throughout the facility," but the OMI only looked at those three patients, didn't look to see if it was a more widespread problem. And that's——

Mr. WALZ. I appreciate that. I'm beyond my time, Ms. Lerner. I'm sorry.

Thank you, Mr. Chairman. I apologize.

The CHAIRMAN. Yes, sir, Mr. Walz.

Mr. Huelskamp, you're recognized for 5 minutes.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

I'd like to go back to some of the testimony we heard on the prior panel. And the first question would be for Dr. Tuchschmidt.

In his testimony, Dr. Mathews stated that when he repeatedly brought up problems with doctors only doing 3-1/2 hours of work during any given 8-hour workday, the consistent explanation he received was that this is the VA.

Considering that response, is it common practice throughout the VA for doctors to work only a proportion of the time they're being paid for?

Dr. TUCHSCHMIDT. No, that's not a common practice. That's not actually an expectation. You know, so I think that——

Mr. HUELSKAMP. Doctor, can you tell me how you know whether that's true or not?

Dr. TUCHSCHMIDT. Well, so I think there was a briefing on capacity in the organization that——

Mr. HUELSKAMP. Yeah, and I'll tell you, the VA briefing said their data was no good. And I've had whistleblowers to that effect.

The second question is with reference to Mr. Davis, if Ms. Lerner could shed some light on this. But you indicated that folks from your association had met with White House Deputy Chief of Staff Rob Nabors and Secretary Gibson about these issues. Were you in on those meetings?

Ms. LERNEr. I was. And Mr. Bachman was, as well.

Mr. HUELSKAMP. Okay. And I'd like to ask you, because Mr. Davis does note that he believes that the Deputy Chief of Staff of the White House, Rob Nabors, leaked his whistleblower complaint, did you visit with Mr. Nabors about this possibility and what the problems and penalties might be for doing such an action?

Ms. LERNEr. My meeting with Mr. Nabors was—did not focus on this matter. I don't know anything about it, quite frankly. My guess——

Mr. HUELSKAMP. Okay.

Ms. LERNER. [continuing].—Is that, and I'm just guessing here, is that Mr. Nabors was trying to probably intervene to help and not to leak someone's name in a vindictive kind of way.

Mr. HUELSKAMP. Well, this goes to the highest levels. You said that you thought they understood very well, but the allegation tonight was that the very folks at the very highest level that we're relying on actually were violating their own whistleblower laws that are very clear.

And I want to ask Dr. Tuchschmidt, how do you inform the employees about the rights in a whistleblower protection? How often do you do that?

Dr. TUCHSCHMIDT. So we have training that employees take in our electronic education system. So there's online training that is available to all employees and supervisory training, as well.

Mr. HUELSKAMP. Is it mandatory?

Dr. TUCHSCHMIDT. Yes, it is mandatory.

Mr. HUELSKAMP. How often do they take this training?

Dr. TUCHSCHMIDT. I believe it's annually.

Mr. HUELSKAMP. And you will certify everyone takes this training?

Dr. TUCHSCHMIDT. We do track it in the—the TMS system tracks——

Mr. HUELSKAMP. Well, your data is sometimes questionable. If you could provide evidence of that, as well.

Following up on a few more things, Dr. Tuchschmidt, in fiscal 2013, Donna Beiter, the director of the VA Greater L.A. Healthcare System, received an $8,985 bonus. Based on the testimony from Dr. Head tonight, including the continued retaliation and discrimination, will there be any effort to pull back or rescind her bonus?

Dr. TUCHSCHMIDT. I really—I can't comment. I don't know. You know, we——

Mr. HUELSKAMP. Okay. Let me ask you about another one then.

Similarly, in the VISN 18, the director of that VISN, which includes Phoenix VA Healthcare System, the director, Susan Bowers, received an $8,985 bonus in fiscal year 2013, as well. Based on what we heard tonight about retaliation, discrimination, will there be any efforts to rescind that bonus?

Dr. TUCHSCHMIDT. So, typically, we—performance awards are tied to a performance evaluation, that a performance evaluation was done based upon the knowledge at the time that was completed. And we don't really believe that we have the authority to go back, once those are done, and change prior performance evaluations.

Mr. HUELSKAMP. And, thirdly, Dr. Tuchschmidt, Mr. Davis's testimony, folks above him, the Deputy CBO, received an $8,252 bonus, and the CBO for Member Service received a bonus of over $7,600. Will there be an effort, or are you going to ignore these—allow these bonuses to remain, as well?

Dr. TUCHSCHMIDT. I think that, again, my answer would be that we don't normally go back and change performance evaluations once they're completed.

Mr. HUELSKAMP. I want to zero in on the 1,241 patient records that were falsified. How many records do you have to falsify in order to be fired as an employee?

Dr. TUCHSCHMIDT. I would hope you don't have to falsify any.

Mr. HUELSKAMP. 1,241 apparently was not enough.

Dr. TUCHSCHMIDT. One would be unacceptable.

Mr. HUELSKAMP. 1,241?

Dr. TUCHSCHMIDT. I can't comment on the specifics of that case.

Mr. HUELSKAMP. Well, I know you're not commenting on a specific case, but you said it's one. But we've verified—the lady next to you has verified 1,241 times. And they're still working serving veterans, when they've falsified data in clear violation of the law and harming potentially veterans. And your response is, well, they still get to keep their job.

Dr. TUCHSCHMIDT. I'd be happy to arrange a time to come and share the details of that with you.

Mr. HUELSKAMP. I would be happy to hear that. But what I think the American public needs to know is, are you really serious about that? Still giving out bonuses, still hearing these reports, and 130 complaints still continue to be investigated.

I yield back, Mr. Chairman.

Dr. TUCHSCHMIDT. I hear you, sir.

The CHAIRMAN. Dr. Tuchschmidt, the VA has come and briefed our staff and said that the VA believes that they have up to 1 year to be able to claw a bonus back. And is it your testimony that, even though fraud was committed, that a bonus is still something that an individual should receive based on the information that was known at the time?

Dr. TUCHSCHMIDT. So I think you're getting out of my swim lane. I don't know the technical answer to that question, but I'm—I am happy to go back and get that answer for you.

The CHAIRMAN. It's called fraud, and that's illegal.

Dr. TUCHSCHMIDT. I understand.

The CHAIRMAN. Mr. O'Rourke, you're recognized for 5 minutes.

Mr. O'ROURKE. Thank you.

I want to continue Mr. Huelskamp's line of questioning about Montgomery and just highlight some of what Ms. Lerner included in her testimony: that, in 2012, a whistleblower who was a surgeon was first alerted to this misconduct by an anesthesiologist during a veteran's preoperative evaluation prior to an operation. So I think that establishes the danger and the threat and the potentially bad outcome for the veteran when we don't have the right information for the anesthesiologist, in this case.

Whistleblower reports these concerns to the Alabama VA management in 2012. They put him on this—him or her—this FPPE evaluation. And during that evaluation, he does this again; he cuts and pastes information onto veterans' medical records.

And then you get OMI involved. And then, far worse than previously believed, the review determines that the pulmonologist engaged in copying and pasting, as Mr. Huelskamp and others have said, in 1,241 separate patient records.

So, a couple things. You keep saying you can't comment on this. I mean, it just defies commonsense and what all of us would expect from anyone, that you would just say that this person will be fired.

I don't know why Ms. Lerner can tell us all these details—and this is now public record—and you can't tell us, and you can't tell the people in Alabama, more importantly, the veterans there, what's happening.

And, also, if we're talking about creating a culture of accountability, what does it say to the surgeon who is the whistleblower? What does it say to the anesthesiologist that this pulmonologist is still working? What does it say to the people who testified in the panel before yours about what happens when you have the courage and take the risk to stand up and alert your superiors to malpractice or malfeasance within a VA?

I think the signal you sent to everybody tonight is, "Don't take that risk. We're not going to do anything." I mean, the sin could not be more glaring than that documented by Ms. Lerner here.

Is there anything that you can say? What would it cost you or the VA or the Federal Government to go out on a limb and say, "We're going to fire that person; he or she should not be working for us"?

Dr. TUCHSCHMIDT. Right. So, as I said earlier, I mean, there are reasons why I feel I cannot go into details here. Right? So there are still active investigations going on into a lot of these issues by the OIG. There are—if I put enough details out there, somebody can make connections, right, back to individuals. And, again, these are complicated issues that——

Mr. O'ROURKE. It's—I don't know how it's complicated.

Let me ask this follow-up question for Ms. Lerner.

In your testimony related to this case, you say, "OSC requested and has not yet received information from the VA to determine if the 1,241 instances of copying and pasting resulted in any adverse patient outcomes."

When did OSC request that?

Ms. LERNER. I'm sorry, I don't know the exact date. We have——

Mr. O'ROURKE. More than a week?

Ms. LERNER. Yeah.

Mr. O'ROURKE. More than a month?

Ms. LERNER. I'm quite sure.

Mr. O'ROURKE. Okay.

Ms. LERNER. And we'll do a final——

Mr. O'ROURKE. And, Dr. Tuchschmidt, what's the response on—I mean, I still don't understand why you can't answer our previous questions about why this pulmonologist is still working, but certainly you could answer this question, about responding to the request to understand how this has affected patient outcomes.

Dr. TUCHSCHMIDT. Yeah, so—I don't know where that response is. I did not know that they had not received something. But I can go back and take care of that and find out where that is and why a response hasn't been received.

I mean, I can say to you that I think that, you know, it is our intention—I'm committed in the job that I am now acting in to try and address these issues——

Mr. O'ROURKE. I'm not convinced—and I apologize for interrupting. I'm just not convinced that you're going to do it. And I don't know you, so you can't take this personally, but it's been reflected in testimony we've heard from almost every representative

of the VA for almost as long as I've been here, which has not been a long time but long enough to know that we have a major problem with accountability and performance. And I'm not convinced that we're going to be able to turn it around, from what I've heard.

I mean, everything was lined up beautifully by the previous panel about the kind of problems and for how long they've existed and what's needed to change this. And then we hear from the VA essentially a non answer that basically sends the message to us and to every employee of the VA that you don't take this seriously.

I mean, you can say you're appalled, you can say you're outraged, you can said you're deeply disappointed, but that's all been said before. What we need now is: This is what we have done, this is what we are currently doing, this is what we will do. And I haven't heard any of that tonight.

And just really quickly, Mr. Chairman, Dr. Jesse, the previous head of the VHA, when we alerted him to these outrageous problems in El Paso, with 36 percent of veterans seeking mental health appointments not being able to obtain one, huge, gross discrepancies between what El Paso VHA was reporting and what we finally learned through the VHA audit was the truth, Dr. Jesse's response was, "Let's not get into assigning blame." In other words, let's not hold anybody accountable, let there not be consequences, let's not change anything we're doing.

I just have to register that very deep, profound disappointment that I have and you've heard from so many others today. And I, through you, ask the Acting Secretary to change the culture now and change the responses that we're getting at these hearings.

Dr. TUCHSCHMIDT. Message heard.

Mr. O'ROURKE. Thank you.

The CHAIRMAN. Mr. Coffman, you're recognized for 5 minutes.

Mr. COFFMAN. Thank you, Mr. Chairman.

Dr. Tuchschmidt, based on the testimony provided by the four whistleblowers here tonight, it appears that the same unethical tactics are occurring at numerous VA medical centers across the country. This would seem to indicate that there is a universal policy in place against whistleblowers that is well-known among all the VA SES-level supervisors throughout the country.

Do you have an explanation for this?

Dr. TUCHSCHMIDT. Well, I don't believe there is any policy or a collusion to suppress whistleblowers amongst the top leadership at the organization. In fact, I think the organization has said today, particularly Secretary Gibson, that we intend to do something about that. The message has clearly gone out to everybody in that June 13th letter that there are consequences for retaliation.

We have to go through a process when those complaints come in, I think, of investigating those so that we treat people fairly and we know both sides of the story and we have the facts before we take action. But I think the organization—the Secretary speaks for the organization. And I think that commitment is there, and I have to take him at his word.

It is clear to me tonight from all of the comments here and from the comments from all of you, I mean, we have an enormous problem. And we are a huge organization; it isn't going to change over-

night. I would—I know we're all impatient, but it's going to take some time, I think, to fix some of these fundamental issues.

It's going to start with, really, leadership. And we have a new Acting Under Secretary, we have a nominee. We will have a new Under Secretary for Health at some point and, I hope, a new Principal Deputy Under Secretary. And I think that the organization—that's the kind of change we need in the organization to get back on the right track. And it's going to take——

Mr. COFFMAN. But how long have you been a part of—you've been a part of leadership in the VA for quite some time. How long have you been a part of the leadership of the——

Dr. TUCHSCHMIDT. For over 20 years, I've been in——

Mr. COFFMAN. Over 20 years. And you testified tonight that this is really the first time that you've become aware of the problems that were brought forward by the whistleblowers tonight. Isn't that correct? That was your previous testimony.

Dr. TUCHSCHMIDT. I learned about these whistleblowers mostly by reading them in the paper, yes. So——

Mr. COFFMAN. And so, you've been in 20 years. Here's the problem: That you've been in leadership within the VA——

Dr. TUCHSCHMIDT. Yes.

Mr. COFFMAN [continuing]. And you've been in leadership for 20 years, and you're just totally oblivious to what is occurring around you, in terms of all the problems, and it really wasn't until it's become a national story that now you're suddenly aware of them.

And I think that that's—I think that really speaks to the culture of the VA and the problem, and that, if not for the whistleblowers who have come forward, we would never be aware of the magnitude of the problems that exist today, because the leadership, or the lack thereof, never brought these issues forward.

And I've got to tell you—let me ask you, are you a veteran yourself?

Dr. TUCHSCHMIDT. No, I'm not.

Mr. COFFMAN. Well, I've got to tell you, you know, if you—the military axiom for this is, I don't think you could lead starving troops to a chow hall. And I've got to tell you, that if the new Secretary, when he comes aboard, after being confirmed by the United States Senate, which I believe he will, has folks like you in senior leadership, he is sending a message to us, the American people, and the veterans of this country that he's not serious about change.

With that, Mr. Chairman, I yield back.

The CHAIRMAN. Ms. Titus, you're recognized for 5 minutes.

Ms. TITUS. Thank you, Mr. Chairman.

I'd like to go back to what I mentioned earlier, and that is my concern about the emergency room doctors at the new Las Vegas hospital. They came and spoke with me, at my invitation, and they talked about the problems there, the lack of leadership, the manipulation of schedules, those who work for the VA directly versus those who are contracted from the private sector who get special treatment.

And I just don't want them to get in trouble because of my initiating an invitation to learn more about what was going on out there. So I would ask you if—maybe you can't provide it here, but

if you can let me know if they are among those cases that you have that have been filed, if anything has come out of Las Vegas.

Mr. BACHMAN. I can't speak to any of the specifics. I can tell you we have not received any complaints from the Las Vegas facility.

Ms. TITUS. Okay. Well, I'm glad to hear that.

I would also like to ask you—we heard, I think Mr. Davis was saying there are different—different things are comfortable for different people. Some whistleblowers go to the press, some hire lawyers, some go to veterans advocacy groups, and some go to their Members of Congress. Well, I think a lot of them come to me. This is our biggest constituent kind of service that we do in the district, was with veterans.

So if someone who works at the hospital, some doctor or somebody who works out there, feels like they want to be a whistleblower and they come to me, tell me what practical advice I give them: Here's what you should do, here's how you're protected, here's who you call, here's the form you fill out. What advice do I give them?

Mr. BACHMAN. The first advice I would give is to please refer them to us. This is the number-one priority in our office right now. We are throwing everything we have at it. We've dedicated over half of our program staff to dealing with these whistleblower retaliation complaints. And so that would be the first step.

And once we get in contact with them, we can find out what their issues are. If for some reason we're unable to help, we can point them in the right direction.

Ms. TITUS. And that would be—they would come to you here in Washington, not in Nevada?

Mr. BACHMAN. Correct, in Washington.

Ms. TITUS. Okay.

All right, thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Mr. Jolly, you're recognized for 5 minutes.

Mr. JOLLY. Thank you, Mr. Chairman. I'll be brief.

I would just like to know, Dr. Tuchschmidt, for the record, this "Stop the Line" conversation that we had, because I do think it's important. You recognize the program; you mentioned the program. It was presented to me at my local hospital as something that was the end-all, be-all for accountability and the ability of employees to step up and make a comment. And yet we had four whistleblowers, clearly with the conviction and courage to come forward, who hadn't heard of the program.

And there's not really a question other than just, I recognize the importance of the program, but clearly it hasn't penetrated to the level that at least was presented to me during my meeting.

And I would just finish tonight, actually, with a bit of a softball question, I'll admit it, but——

Dr. TUCHSCHMIDT. I appreciate it.

Mr. JOLLY [continuing]. It's an important question. And I'm going to give you the rest of the time to answer it.

You've apologized tonight. You've spoken of accountability. You've mentioned being appalled, speechless. You've passed your cell phone number. Mr. Matkovsky impressed me several weeks ago by apologizing and referring to what he called a "crisis of integrity."

I notice, as a new Member of Congress, we have heard a change in tone under the Acting Secretary, and I will say but for the witness who, 2 weeks ago, said the system was dishonest, which, frankly, I think was a deferral of responsibility. But, by and large, I think we've seen a change in tone.

You've been with the VA more than 20 years; is that——

Dr. TUCHSCHMIDT. Yes.

Mr. JOLLY. Here's the softball for you, but also exceedingly important: Have you noticed a change in the last 6 or 8 weeks as a result of the attention? How we got here is another question. Do you believe, with 20-years-plus experience at the VA, that we are entering a new era of leadership within the VA, regardless of who steps into the position?

And the time is yours on that one.

Dr. TUCHSCHMIDT. I do.

So I think that there are many places around this system that are phenomenal, where we have outstanding care, better care than exists in private sector. We have places that have outstanding access.

Our problem, I think—one, I agree with you absolutely, we have a crisis of integrity. How we restore that is going to be a slow and painful process.

The clinical issues, I think our biggest issue is that we do not have a uniform, systematic approach to these things, and so we have pockets of excellence and places that are not performing so well.

The amount of activity in the 4 weeks that I've been in this job and have had the opportunity to be aware of these problems has been outstanding. I mean, the Secretary's out there. We are sending hot teams into the facilities—I think we've sent teams into Phoenix now three or four times—to help them, to ask them what do they need. And we—I spend my days trying to get them what they need.

I can tell you that 12 of those 20-something years I was a facility director. I practiced as a clinician in the intensive care unit. I'm a critical care physician. I practiced there. I knew what was going on in my facility. I walked the halls. My values I wore on my shirtsleeve. And people knew where I stood on issues around integrity, around bringing problems forward, about people coming together and solving those problems.

There was no doubt in my mind about what it took to make sure the patient was the end-all and be-all of what we took care of. That's why we were there, every one of us. And if you weren't there for that purpose, then you better take a hike. That was clear, I think, to everybody.

And I don't know that I'm the perfect shining example because, quite frankly, I spend many nights sitting in bed wondering what I could have done differently, what I personally could have done differently. When could I have raised my hand? Could I have pushed back harder? What did I not know that I should have known? Many sleepless nights.

I don't know that I am the epitome of what it's going to take. But I think it's going to take leadership who really—not just at the Secretary level, not just at the Under Secretary level, but all the way

down to the service chief—who owns the problem and says, we can fix it.

And I think we have a lot of great people in this organization that will step up to the plate. And I am confident that we're going to bring new people into the organization today to help solve those problems.

Mr. JOLLY. Okay. Thank you very much.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Jolly.

Thanks to the panel.

Based on our hearing today, we would expect the Secretary of Veterans Affairs to establish a long-term plan of intended actions, with target dates, that would determine what actions to take against VA managers when reprisals have been found to have taken place, notifying on a periodic basis all employees of their whistleblower rights, and measuring the effectiveness of such actions, such as a periodic survey of employees, and designing and implementing a system for tracking overall whistleblower complaints—complaints for which reprisal was determined or the complaint was settled.

In addition, we recommend that VA analyze this data periodically to ascertain whether additional steps are needed to ensure that reprisal is not tolerated.

With that, I ask unanimous consent that all Members would have 5 legislative days to revise and extend their remarks and include any extraneous materials. Without objection, so ordered.

The CHAIRMAN. I want to thank both panels of witnesses and the audience members for joining us at tonight's critical hearing on the importance of whistleblowers and effective oversight investigations.

And, Dr. Tuchschmidt, one last question: Is Ms. Helman still on the payroll?

Dr. Tuchschmidt. I don't honestly know the answer to that question.

The CHAIRMAN. Does she work under your purview?

Dr. Tuchschmidt. Many layers down.

The CHAIRMAN. But you don't know if she still is on the payroll?

Dr. TUCHSCHMIDT. I would have to get an answer and take that for the record.

The CHAIRMAN. Okay.

With that, this hearing's adjourned.

[Whereupon, at 12:01 a.m., Wednesday, July 9, 2014, the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF JEFF MILLER, CHAIRMAN

Good Evening.

This hearing will come to order.

I want to welcome everyone to tonight's hearing titled, "VA whistleblowers: Exposing inadequate service provided to veterans and ensuring appropriate accountability."

I would also like to ask unanimous consent that representative Tom Price from the state of Georgia be allowed to join us here on the dais and participate in tonight's hearing.

Hearing no objection, so ordered.

Tonight, we will hear from a representative sample of the hundreds of whistleblowers who have contacted this committee seeking to change the VA to improve patient safety and better serve veterans who have served this country.

We will also hear from the office of special counsel regarding its work protecting VA whistleblowers and the vital information they provide.

Representatives of VA will also be here to answer for the department's reprisals against whistleblowers and its continuing failure to abide by its legal obligation to protect employee rights to report waste, fraud, abuse, and mismanagement to the inspector general, to the special counsel, to congress, and to this committee.

It is important to emphasize that the national scandal regarding data manipulation of appointment scheduling did not spring forward out of thin air at VA. Deceptive performance measures that serve as window dressing for automatic SES bonuses have been part of the organizational cesspool at VA for many years.

Instead of being a customer driven department dedicated to veterans, the focus instead has been on serving the interests of the senior managers in charge.

The manipulation of data to game performance goals is a widespread cancer within the VA.

We have often heard that VA is a data rich environment, but when data is exposed as vulnerable to manipulation, it cannot be trusted.

Until recently, VA would continue to trot out the tired canard that patient satisfaction exceeds the private sector.

That may be true at a few select VA centers.

However, as our colleague, Mr. O'Rourke, demonstrated through local polling, such results have been over generalized.

Moreover, during the course of the past year, this committee has held a series of hearings showing a pattern at VA of preventable patient deaths across the country, from Pittsburgh to Augusta to Columbia and to Phoenix.

VA's satisfaction results are refuted by these tragic outcomes.

In every one of these locations, whistleblowers played a vital role in exposing these patient deaths at VA.

Whistleblowers serve the essential function of providing a reality check to what is actually going on within the department.

At great risks to themselves and their families, whistleblowers dare to speak truth to power and buck the system in VA designed to crush dissent and thereby alter the truth.

Tonight, we are very fortunate to have three distinguished physicians testify with regard to their experiences in the VA.

We will also hear from a conscientious program manager in VA's national health eligibility center who will show that the disease of data manipulation may have spread to the initial eligibility determinations for medical benefits.

None of these whistleblowers lost sight of the essential mission of VA to serve veterans.

They understand that people are not inputs and outputs on a central office spreadsheet.

They understand that metrics and measurements mean nothing without personal responsibility.

Unlike their supervisors, these whistleblowers have put the interests of veterans before their own.

Unfortunately, what all of these whistleblowers also have in common is the fear of reprisal by the department.

They will speak of the many different retaliatory tactics used by VA to keep employees in line.

Rather than pushing whistleblowers out, it is time that VA embraces their integrity and recommits itself to accomplishing the promise of providing high quality health care to veterans.

In order to make sure there is follow through at VA, I have asked my staff to develop legislation to improve whistleblower protections for VA employees and I invite all members of the committee to work with us towards this end.

With that, I now yield to ranking member Michaud [MEE–SHOW] for any opening remarks he may have.

Thank you, ranking member Michaud.

I ask that all members waive their opening remarks as per this committee's custom.

Based on our hearing today, we would expect the secretary of veterans affairs to establish a long–term plan of intended actions with target dates for:

(1) Determining what actions to take against VA managers when reprisal was found to have occurred;

(2) Notifying on a periodic basis all employees of their whistleblower rights and measuring the effectiveness of such actions, such as with a periodic survey of employees; and

(3) Designing and implementing a system for tracking overall whistleblower complaints, complaints for which reprisal was determined, or the complaint was settled.

In addition, we recommend that VA analyze these data periodically to ascertain whether additional steps are needed to ensure that reprisal is not tolerated.

I ask unanimous consent that all members have five legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

I would like to once again thank all of our witnesses and audience members for joining us for tonight's critical hearing on the importance of whistleblowers to effective oversight investigations.

With that, this hearing is adjourned.

PREPARED STATEMENT OF HON. MIKE MICHAUD

Thank you Mr. Chairman.

This Committee has held many hearings over the years on problems with access to VA health care. At each of these hearings, problems were disclosed and the VA promised to improve. But little has changed.

VA is widely known to have a culture of denying problems and not listening to feedback—be it from Congress, veterans or its own employees.

VA has had a reputation as being intolerant of whistleblowers. So far in this fiscal year, nearly half of the matters transmitted to agency heads by the Office of Special Counsel, seven out of 15, involve the VA.

According to the OSC, it currently has 67 active investigations into retaliation complaints from VA employees, and has received 25 new whistleblower retaliation cases from VA employees since June 1, 2014.

A recent New York Times article stated that within the VA there was a "culture of silence and intimidation."

Acting VA Secretary Gibson recently stated that he was "deeply disappointed not only in the substantiation of allegations raised by whistleblowers, but also in the failures within VA to take whistleblower complaints seriously."

Within VHA, the problem of intimidation and retaliation may be magnified by what some considered the "protective" culture of the medical profession.

It is often thought to be against the "code" to point out a colleague's mistakes. Or, where a nurse or attendant is told it is not "appropriate" to question a physician or surgeon.

The natural tendency is to close ranks to deny that problems exist, or mistakes were made.

So, after we listen to the testimony before us this evening—from whistleblowers, the Office of Special Counsel, and the VA, will anything change? How do we fix this culture and encourage all VA employees to step forward to identify problems and work to address them? Changing a culture is not easy. It cannot be done legislatively, and it cannot be done by throwing additional resources at it. Talk is cheap and real solutions are hard to find.

It is clear to me that the VA, as it is structured today, is fundamentally incapable of making a real change in its culture. I note that Acting Secretary Gibson announced today that he was taking steps to restructure the Office of Medical Inspector by creating a "strong internal audit function which will ensure issues of care quality and patient safety remain at the forefront."

This is an improvement, but it raises additional questions regarding how this restructuring will better enable OMI to undertake investigations resulting from whistleblower complaints forwarded by the OSC, or how it will have the authority to ensure that remedial actions are taken by the appropriate components of the VA.

Time and again, as the June letter from OSC demonstrates, the VA found fault, but determined that these grave errors did not affect the health and safety of veterans. Anyone reading the specifics of any of these cases will find this "harmless error" conclusion, as

stated by the OSC to be a "serious disservice to the veterans who received inadequate patient care for years[.]"

I agree with the OSC's June 23rd letter—"This approach has prevented the VA from acknowledging the severity of systemic problems and from taking the necessary steps to provide quality care to veterans."

We all seem to have the same goals this evening—we want all VA employees to feel comfortable raising problems and having them addressed without fear that raising their voices will mean the end of their careers.

The VA has stated that it wants to make fundamental changes in its culture so that workforce intimidation or retaliation is unacceptable. Talk is cheap. Real change is difficult.

I would propose that the very first order of business at the VA is to take accountability seriously. If any VA employee is shown to have intimidated or retaliated against another VA employee then that employee should be fired.

The VA should have a zero tolerance policy for whistleblower intimidation or retaliation. As I see it, effective leadership and real accountability is the only way to begin the process of institutional change. I hope tonight is the beginning of that change.

Thank you Mr. Chairman, and I yield back the balance of my time.

PREPARED STATEMENT OF HON. CORRINE BROWN

Thank you, Mr. Chairman and Mr. Ranking Member, for calling this hearing today.

As we have learned over the past few months there are serious problems at the VA. We now need to focus on what can be accomplished by these hearings.

How do we address the change of culture at the VA? Currently, there is no leadership at the VA. All the top positions are "acting." We can hold hearings from now until the cows come home and if we don't work with a permanent leadership at the Department, nothing will be accomplished for all these hearings.

During the Cold War, in order to feel comfortable with the Soviet Union, we had what were termed Confidence Building Measures.

Continuing to lob bombs from this dais will not help the veterans needing health care.

The VA operates 1,700 sites of care, and conducts approximately 85 million appointments each year, which comes to 236,000 health care appointments each day.

The latest American Customer Satisfaction Index, an independent customer service survey, ranks VA customer satisfaction among Veteran patients among the best in the nation and equal to or better than ratings for private sector hospitals.

I am confident in the health care our veterans in Florida are receiving. With eight VA Medical Centers in Florida, Georgia and Puerto Rico and over 55 clinics serving over 1.6 million veterans, veterans are getting the best in the world. Over 2,312 physicians and 5,310 nurses are serving the 546,874 veterans who made near-

ly 8 million visits to the facilities in our region. Of the total 25,133 VA employees, one-third are veterans.

PREPARED STATEMENT OF HON. NEGRETE MCLEOD

Thank you, Mr. Chairmen for having this hearing. VA's history of ignoring reported problems in the delivery of health care and not protecting whistleblowers is unacceptable and must change. I appreciate Acting Secretary Gibson announcing that the Office of Medical Inspections will be reformed. These reforms must be sincere and meaningful. VA must have an open and honest conversation about its practices and what steps must be taken to improve care for veterans. Thank you and I yield back.

PREPARED STATEMENT OF DR. JOSE MATHEWS

Executive Summary

Since the tragic events of September 11, 2001 and our country's involvement in Afghanistan and Iraq, millions of troops have deployed overseas in the interest of protecting our nation and advancing others. Although the VA was charged with the responsibility of providing services to generations of veterans, it has only been in the most recent years that mental health care treatments for conditions like PTSD have been better understood with modalities of treatment reaching heightened rates of efficacy. We know now that with proper treatment of mental health concerns, joblessness, homelessness, and suicide risk can be mitigated and in some instances eliminated. And it is from this perspective that the VA's role in treating veterans should be evaluated.

It is the responsibility and duty of the federal government to provide these esteemed service members with the best health care possible.

I can only speak from my personal experiences and observations as the Chief of Psychiatry at the St. Louis VA. There, the healthcare system as currently exists, has proven only to be a maze of bureaucracy and red tape for veterans to weave through upon their return home. Instead of being provided with the immediate medical treatment and VA related benefits they are entitled to, the St. Louis, VA has failed the same vulnerable population it was designed to serve.

The men and women who have so bravely served our country deserve a system that will be responsive and efficient; and more importantly, will not fail them. The only way to ensure effective and timely access to health care is to provide transparency and to create objective metrics that evaluate the care that is provided on a regular basis. Perhaps more poignantly, the existing resources to provide this care is simply not being managed effectively.

There are several initiatives I would like to propose that will improve access and quality of health care afforded to veterans. These initiatives include: (i) objective metrics to increase transparency; and, (ii) ensuring accountability by amending the Whistleblower Protection Enhancement Act, which has proven inadequate for

whistleblowers who make allegations regarding risks to veteran health and safety.

These recommendations will provide a paradigm to ensure that the quality of care is not only maintained but exceeded. The Department of Veterans Affairs should be a world leader in the treatment of combat related medical conditions; not an institution where mismanagement and indifference breaches a community's prevailing standard of care.

Mr. Chairman and distinguished members of the committee: I am honored to appear before you today to speak about my experiences while serving in the capacity as the Chief of Psychiatry with Department of Veterans Affairs in St. Louis, Missouri.

In order for you to better understand my connection and interest in veteran related health care matters; I would like to provide you with some brief information about myself. I am a first generation immigrant from India and my father is a combat veteran of the Indian Army. I am well acquainted with the aftermath of a war and the toll it takes on the warrior and their family. I have had a longstanding interest in understanding mental illness, particularly mood disorders and trauma related illnesses. I was fortunate to have had the opportunity to study psychiatry and complete my residency training at Washington University in St. Louis, a top-notch psychiatry program in the country. I subsequently completed my fellowship training in forensic psychiatry at Yale University.

I accepted the position of the Chief of Psychiatry at the St. Louis VA in November 2012. I considered my job as a mission to improve the mental health care of our veterans. I worked hard to understand the VA system of care and I diligently followed-up on veteran complaints about their mental health care. I was very concerned about some of the complaints I reviewed that were about poor access to care. I studied the official VA productivity data and this data showed that the psychiatrists at the St. Louis VA were amongst the most productive in the nation. Based on this, I concluded that I needed more psychiatrists to provide good, timely and safe mental health care to our veterans. During the course of my employment, and as I identified deficiencies I took actions to correct these deficiencies. Notwithstanding, the management structure of the VA not only precluded me from correcting the deficiencies, but treated me adversely as a result of my initiatives to make changes. This represented a dramatic departure from my experience working in private and academic settings.

A. Defining the Problem

I requested an extra full time psychiatrist position and this was approved by the VA administration. However, some of the veteran complaints still persisted. Including the complaint of a veteran who came to the clinic with a deterioration of his illness and who instead of being evaluated by a provider, was turned away with an appointment scheduled for months later. Another case that I found alarming involved a disabled veteran without independent transportation, who was experiencing worsening of his serious mental illness and who had traveled a long distance to the VA clinic to get help. Again, he was not seen by his provider or any other provider, or any provider for that matter. His medications were not refilled;

instead, he was sent away with an appointment that was no fewer than 48 days later. I found it difficult to believe that no one could spare 15 minutes to address this veteran's urgent medical needs. I wanted to find the answer to a simple question: "How busy are the providers at the outpatient clinic?"

The St. Louis VA, to my surprise, could not identify the average number of veterans seen by a provider/day or the time a provider spends on direct patient care/day. I asked other psychiatry Chiefs to estimate similar data at their facilities by contacting them through a national e-mail group that encompassed other VA facilities and I received answers that ranged from 8 to 16 veterans/day/psychiatrist. I also worked with a VA database administrator and my outpatient psychiatry director to find out how many veterans were actually being seen/day/psychiatrist at the St. Louis VA. I was interested in estimating time spent on direct patient care. I wanted to know the amount of available physician time for direct patient care and the amount of actual time spent in direct patient care in order to estimate utilization of expertise (available time/actual time).

I was shocked to find that outpatient psychiatrists at the St. Louis VA were only seeing on average, 6 veterans/8 hours for 30-minute appointments with rare 60-minute appointments (3/week). I could only account for 3.5 hours of work during an 8-hour workday. In essence, we were utilizing less than 50% of the available physician time for direct veteran care. I checked my data multiple times and once I was confident that my data was accurate, I investigated why there was such low utilization of psychiatrist time, what the wait time for care was for the veterans and whether we were able to engage and retain our patients in ongoing mental health care and what the veteran experience of care was at the VA. The answers I got were alarming:

1. Low utilization of expertise:

a. I discovered that veterans were not being scheduled in all the available appointment slots. Three slots out of the possible 12 (1.5 hours) were inexplicably blocked from scheduling each day.

b. There was a very high no-show rate (35%).

2. Wait times:

a. I found that the wait time for a new appointment was 25 days and for a follow-up appointment was 30 days after the desired follow-up date.

3. Retention in care:

a. I was most troubled by my finding that 60% of the veterans were dropping out of mental health care after one or two visits with their psychiatrist.

4. Veteran Experience:

a. There was a lack of meaningful veteran satisfaction measure. The surveys administered by the VA that I saw were not done with safeguards to preserve anonymity and confidentiality e.g., the treating provider would hand out the surveys to the veterans and would also collect the completed surveys: From the veteran's perspective, it would be extremely difficult to make any negative assessment/comments under these circumstances as one cannot feel confident about confidentiality and will have concerns about their opinion impacting the care they receive.

B. Disclosing the Inadequate Care to Veterans

I discussed my data with the Chief of Staff, Chief of Mental Health and my staff. The staff psychiatrists contested my data and offered various unconvincing reasons for not seeing more veterans/day (usually this involved pointing fingers at the scheduler/person tasked with reminder calls/other specialties). To address this, I collected prospective data (going forward) for 1 month for all the specialties (Psychiatry, Psychology, Social Work, Nurse Practitioners) and 22 weeks (5 months) of data for the psychiatrists (other specialties opted out).

I could only account for less than 4 hours of work during an 8-hour workday for any of the staff in Mental Health (psychiatry, psychology etc . . .) It was as if there was an agreement amongst all the clinic employees to only work for less than half the time they are paid to work. An agreement amongst administration and staff that on paper everyone would be "productive" and that everyone would qualify for "performance" bonuses.

I argued that this situation was unethical and unsafe for our veterans and that this needed to change urgently. I ran my intervention strategies by the Chief of Staff and I instituted three changes:

1. I increased the scheduling grid to accommodate 19 veterans/day in the hopes of seeing, on average, 12 veterans/day/psychiatrist and when this milestone was accomplished, to reduce the scheduling grid to 16 veterans/day to maintain access to care.
2. Instituted a strict policy of not turning away a veteran who had presented for care. I instructed the clinic to arrange for the veteran to be evaluated by other providers if a provider calls in sick. I put myself in this pool and I saw veterans on three occasions to underscore my commitment to this policy.
3. I instructed outpatient psychiatrists to stratify their patients into two groups: high intensity care and usual intensity care. I wanted more intense monitoring and follow-up for those in high intensity care group.

I was also able to secure philanthropic support for a pilot program to collect real time, meaningful veteran satisfaction survey with questions such as: Did your provider address your concerns today? Do you know when your next appointment is? Using ipads and real time data integration.

There was a significant amount of resistance from many psychiatrists and other specialties. I was yelled at on many occasions, I was told repeatedly, "this is the VA" to explain away the poor access to care. I persevered and I had partial success in increasing the number of veterans seen/day/psychiatrist; in reducing the wait times and in implementing a real-time veteran satisfaction survey.

I wanted to focus on four core meaningful metrics:

1. Time to care.
2. Utilization of resource (available/actual)
3. Veteran retention in care.
4. Veteran satisfaction with care.

I had argued that if the above metrics were headed in the right direction, we would be advancing towards our goal of creating a care environment where we could honestly refer a loved one, and if these metrics were not improving, other metrics (e.g., productivity measures) were meaningless.

I observed several unethical practices at the VA and I would bring this to the attention of the administration or address these if they were my staff.

1. Some of the psychiatrists were not respecting their tour of duty time commitments. I called them on it that resulted in improved behavior.

2. I was part of a search committee for a senior position at the VA and I was concerned about a particular candidate not being accorded proper consideration. I wrote a frank e-mail to all the members including the Chief of Staff where I argued that this was both unethical and possibly illegal.

3. I had a transgender veteran complaint about the quality of psychological evaluation report that had resulted in the denial of hormonal treatment. I found this psychological report grossly inadequate and I strongly argued for a second opinion for this veteran. This resulted in the then Chief of Psychology falsely vouching for the "expertise" of the evaluating psychologist. Subsequently I found out that the evaluating psychologist was placed on probation, that her clinical privileges were restricted, that she had many veteran complaints and that she was hired despite concerns about her competence, I requested a meeting with the Chief of Staff and the Chief of Psychology where I voiced my concern about this incident and I suggested that this psychologist's work be reviewed by a psychologist from outside the St. Louis VA. The Chief of Staff did not seem concerned and the next veteran complaint against this psychologist for a similar issue was deliberately hidden from me.

4. I had concerns about two avoidable deaths:

a. One involved a young OIF/OEF veteran who was not assessed properly at the VA, whose medication management was sub-standard and who was discharged the very next day after his inpatient admission. My request for a Root Cause Analysis was not honored.

b. An elderly veteran was not assessed properly in the ER and he died shortly after he was admitted to the psychiatry inpatient unit.

5. A suicide attempt by a veteran in the inpatient unit while the Joint Commission was reviewing the VA was covered up and this incident was not reported to the Joint Commission. A safety barrier was breached during this attempt and this vulnerability was not addressed promptly as this event was not reported to the Joint Commission, hence, corrective actions were deliberately delayed at real risk of harm to the veteran.

6. The Acting Chief of Mental Health had opened up a back channel communication with the psychiatrists who were opposed to my increasing access to care and with my demanding accountability from all. I had met with the Chief of Staff and the Acting Chief of Mental Health regarding this. The Acting Chief of Mental Health had apologized to me for his behavior, I accepted his apology and his assurances that he would fully support my efforts to improve access to care.

7. However, shortly thereafter, while I was on paternity leave, the Acting Chief of Mental Health was the person who determined that an Administrative Investigation was warranted based on the complaints he got from the very disgruntled psychiatrists who were opposed to my initiatives.

C. Retaliation for Whistleblower Disclosure and Subsequent Disclosures

On the heels of disclosing the deficiencies and barriers to care, the Chief of Staff called me into a meeting on August 26, 2013 to inform me that there was a "mutiny" and that to "protect" me "and the VA" he was authorizing an Administrative Investigation to investigate the allegation that I had created a hostile work environment for the staff psychiatrists. I reminded him that the staff psychiatrists had nominated me for an award before I had discovered the extremely poor work ethic and I had started to demand accountability. He told me that this would give people time to "cool off." He assured me that I did not need an attorney and that he did not anticipate this process to take more than a few months and that I would be immediately detailed to Compensation and Pension and was not to access any of my patient files or information pertaining to the provider/patient care ratio.

Although provided with very little information about the exact nature of the investigation against me, my understanding is that the Chief of Staff and the Chief of Mental Health met with all the staff psychiatrists after my meeting with the Chief of Staff. The three of the psychiatry directors were excluded from this meeting. This meeting was described to me by some of the psychiatrists I had recruited as "embarrassing, bad-mouthing" and I got a phone call from a concerned psychiatrist who wanted to know if I was fired.

I continued doing Compensation and Pension evaluations throughout the pendency of the "investigation." I independently filed a complaint with the Office of Special Counsel and although I disclosed all of this information, because of the way I phrased the information, the Office of Special Counsel declined to find that I had establish that I was subject to a prohibited personnel practice. I was forced to retain counsel and only with the assistance of an attorney was able to craft a complaint that has engendered the interest of the Office of Special Counsel; which only recently notified me last week that they were referring my complaint for investigation.

In broad brush stroke terms, since the time of my disclosures last year, the VA has retaliated against me in the following manner:

1. I was completely removed from my position as Chief of Psychiatry;
2. I was forbidden from contacting other psychiatrists and my access to the database I set up to monitor the number of veterans seen by provider each day was terminated;
3. The independent funding for the veteran satisfaction survey project I secured was put on hold because of my removal from the Chief position;
4. Two excellent psychiatrists I had worked hard to recruit, who had interviewed at the VA, were from excellent training programs (Hopkins and Harvard) decided not to join the VA;
5. A hostile work environment was created in so much as, some of the staff psychiatrists outwardly mocked me;
6. I had an earlier performance review completed by Dr. Steve Gaioni who was the ACOS for Mental Health until July 2013 that

was a reasonable assessment however I did not agree with his assessment of my management as Dr. Gaioni would counsel me to "go slow" where I saw an urgent need to improve access to care. I was re-evaluated by Dr. Metzger and he used a "performance" metric that I could not understand but it covered 5 weeks of my work from October 1 2013 until November 4 2013 and he determined that I had only met 50% of the goals he had set for me that was unbeknownst to me and was set after I was put on the administrative investigation. I refused to sign this document, however Dr. Welling, the Chief of Staff determined that this was an accurate representation of my work for the entire fiscal year and as represented by their approval. This is why almost every psychiatrist got the full performance pay they were eligible for based on bogus "productivity" data.

7. I was overlooked for promotion opportunities. More specifically, The Chief of Staff, on at least two occasions, pre-selected individuals for the Associate Chief of Staff position (a position for which he was aware I intended to apply), before the position was even advertised. Although, as the Agency was also aware, the fact that I was under investigation, impacted my ability to compete for positions.

8. Approximately one year after my initial disclosures, and although, no one at the VA had ever disagreed with my calculations concerning the number of veterans seen on a daily basis, the St. Louis, VA defamed my professional reputation and issued a press release suggesting that the VA's own careful investigation showed that the actual number was more than double of what I had found (14). This was blatantly false.

9. After my disclosures to the Offices of Senators Blunt and McCaskill I was contacted by the VA Privacy officer, who suggested he was investigating violations of PHI; which I did not. They filed complaints with the Federal Prosecutors office and the OIG. I had to have my attorney intervene again on my behalf.

10. Shortly after Senators Blunt and McCaskill made an inquiry into the caliber of patient care at the St. Louis, VA, the Chief of Staff called me into his office and demanded to know what my "end game was? Where is all this going?" I told him that I did not know and that I had no control over how everything was going to play out. This meeting ended abruptly.

11. I discovered that false data was entered into the medical records of veterans in June of 2014. After disclosing this to Acting Secretary Gibson, I was immediately reprimanded. More specifically, both myself and a colleague were subsequently instructed to report to a meeting with the Chief of Staff, who stated in pertinent part that it was Acting Secretary Gibson's expectation that the "chain of command is followed." The Chief of Staff went on to state that "I am telling you what the chain of command is, this is what it is, you work for me." I was offended by this and I told him that I thought I was working for the US government and not for him. He reiterated that it was Secretary Gibson's expectation that we first discuss any issues first with Dr. Metzger, if there is no resolution, to "go up the chain of command." I clearly felt that I was being reprimanded for writing to Secretary Gibson and that I should resolve the issue "locally first." He commented that this was

the best way to manage any organization and that this was the "safe" thing to do. The way he said safe and the manner he lingered on it made it clear to me that he was conveying a gag order and a threat. I called him on it and I asked him if this was a gag order. He said no but that this was the expectation of Secretary Gibson.

He also stated that he wanted to tell us that even discussing de-identified information with outside agencies and looking for information in patient chart may constitute privacy violation and he wanted us to be aware of this. I asked for clarification if he was telling me that I could not contact OIG, OSC or Senators, he said that this is not what he meant but for us to be mindful of the fact that the VA takes veteran privacy very seriously. The spirit and tenor of this meeting was in direct contradiction to the memo Secretary Gibson had sent that called for Whistleblower protection.

12. Shortly after I disclosed the false data entry in June of 2014, my official protected time for research was revoked.

D. Crafting an Effective Solution

Any effective mechanism for improving Veteran care will necessarily incorporate transparency and accountability; neither of which is mutually exclusive of the other.

I have had the opportunity to think deeply about some tangible and concrete measures that the Congress and White House could take immediately to restore trust and faith in the St. Louis, VA by focusing on two elements. The First component of which applies to patient care and transparency:

Safe Guarding Patient Care

1. Data Integrity: VA data must be managed by an independent entity. Transparently tracking just four simple metrics can yield huge benefits:

a. Wait times for each specialty/procedure: This could be available on a real-time basis.

b. Reasonable time veteran satisfaction measure: We have the technology to implement a concise, well validated measure of veteran satisfaction on a reasonable time basis (compiled weekly), at the point of contact to get a more complete set of veteran experiences.

c. Utilization of expertise: Available time/actual time spent by providers.

d. Retention in care or the attrition rate of the veterans.

2. Employee Discipline: Those individuals in direct patient care role must not have life-time tenured positions. I think that this "job security" is a big factor in veteran interest not being central which then ironically threatens the very existence of VA as a health care system.

Protecting and Fostering Transparency: As currently drafted, the Whistleblower Protection Enhancement Act (WPEA) as enacted, has done little to shield the professional rebuke that has occurred following my disclosures. Moreover, some of the events that have happened, although impacting my professional career, fall beyond the ambit of the definition of Prohibited Personnel Practice (PPP). For this reason alone, the WPEA should be amended to require the VA to maintain the status quo for all whistleblowers who allege

breaches to the standard of patient care. This will ensure timely investigation and resolution of the allegations and will preclude the VA from conducting "administrative investigations" that, while harmful and professionally detrimental, may not fall neatly with the confines of the PPP.

Perhaps more importantly however, is the personal and financial sacrifice associated with the disclosures. Although I have a medical degree and am a Yale trained psychiatrist, I could not navigate the OSC process without the benefit of counsel. Not every whistleblower will be able to afford to retain an attorney to provide the legal advice that is absolutely necessary when an Agency begins making professional and potentially criminal allegations; all of which are grossly unfounded. Even now that OSC is involved, an investigation has not been completed and I am required to commence an action before the Merit Systems Protection Board if the OSC declines to prosecute or if the OSC is not successful in negotiating an agreeable resolution to my complaint. To that end, the WPEA should be amended to make optional the need to exhaust administrative remedies by first filing whistleblower appeals with the OSC and to provide for the mandatory payment of treble attorney fees for prevailing parties in order to provide VA employees with greater access to private legal representation at all stages of the whistleblowing process.

I would, and will continue to, blow the whistle a thousand times over again to protect the patients I treat; but some of the barriers I have identified may for example prove too onerous a burden for others to sustain. For this reason alone, the laws must change to afford actual and timely protection for whistleblowers.

The recommended solutions identified will result in the following:

Veterans: With readily available wait times and satisfaction measure, a veteran will have the choice to obtain care at a facility that optimizes acceptable wait time with satisfactory care. This will lead to a more even utilization of specialty care that in-turn will improve efficiency by distributing care. The cost savings from early intervention and reductions in secondary complications could justify travel assistance or other incentives to distribute care.

Policy Makers: A more accurate and meaningful measure of resource utilization and hospitals/ specialties needing closer scrutiny will be available to guide sounder policy. VA will not be saddled with poorly performing employees who may be toxic to veterans health.

Veteran Service Organizations: More effective monitoring of the VA with transparent reasonable time data.

Taxpayers: Determine if we are getting value.

Whistleblowers: Will be encouraged. This will create transparency in their individual VA institutions without the fear of professional rebuke and potentially, financial devastation.

I would like to deeply thank the Committee for the privilege of appearing before you today on, what I view, to be a defining moment in how our Government responds to the mental health needs of veterans. Thank you.

The CHAIRMAN. Thank you Dr. Mathews. We'll have an opportunity, each of us, to ask questions and get into specifics a little bit later on.

PREPARED STATEMENT OF DR. CHRISTIAN HEAD

Introduction

Dr. Christian Head [1] comes before Congress to testify, not motivated by any political agenda, but based purely on a genuine interest in seeking solutions to address employee mistreatment, but most importantly, to improve the healthcare provided to our Country's heroes. Dr. Head submits this testimony in response to Congress's request to appear and testify on this issue.

Dr. Head is uniquely qualified to testify regarding issues within the VA system. Dr. Head is a world-renown, board certified Head and Neck Surgeon. Between 2002 through 2013, Dr. Head held dual appointments at the UCLA David Geffen School of Medicine becoming a tenured Associate Professor in Residence of Head and Neck Surgery, as well as an attending surgeon at the West Los Angeles Campus of the VA Greater Los Angeles Healthcare System ("GLAHS"). In 2007, Dr. Head was promoted to Associate Director, Chief of Staff, Legal and Quality Assurance within GLAHS.

Dr. Head's clinical and academic successes over the years have been numerous. However, despite Dr. Head's many accomplishments and contributions to the medical profession, Dr. Head has endured and witnessed, firsthand, illegal and inappropriate discrimination and retaliation of physicians, nurses, and staff members within GLAHS. Throughout this testimony, Dr. Head will speak on the growing number of complaints coming from VA employees, complaints ranging from racial, gender, and age discrimination and harassment to complaints regarding substandard patient care and treatment.

Additionally, Dr. Head will address the inappropriate and often illegal response, or at times lack of response, by VA administration in regards to complaints by hospital employees. For example, this testimony will focus on how administrators and supervisors within GLAHS have created a climate of fear and intimidation, where the system not only fails to protect whistleblowers, but actively seeks to retaliate against them.

Further, Dr. Head's testimony here will discuss the general lack of accountability of VA administrators and supervisors who actively retaliate against and ostracize hospital employees who attempt to speak out against illegal behavior. Dr. Head will testify, firsthand, about the climate within the GLAHS which perpetuates this illegal behavior, due in large part to the system's failure to take any action against certain individuals. Specifically, how wrongdoers are left in positions of high leadership to continue their illegal behavior without recourse.

Dr. Head's testimony will further discuss how the current morale of employees within GLAHS is dangerously low. Dr. Head's testimony will discuss how the system's failure to properly respond to

[1] To avoid confusion, I will refer to myself in the third person throughout this testimony.

complaints leaves employees within GLAHS with a sense of helplessness, creating undue stress and anxiety amongst those attempting to provide quality healthcare to our Country's veterans.

Finally, but most importantly, Dr. Head's testimony here will explain how this dangerous climate of intimidation and retaliation against whistleblowers negatively affects patient care. Dr. Head will discuss how he has witnessed, firsthand, veterans receiving below-standard healthcare, or no healthcare at all, because of the retaliatory behavior and lack of accountability within the system.

Background

Dr. Christian Head is a prominent Head and Neck Surgeon, known worldwide. As some would say, "one of our finest surgeons in Southern California. . . . [Who is] generous with his time and talent, helping Veterans and giving back to our community both locally and nationally. . . . [W]ho will make a difference in our world with his skills as a surgeon, his scientific research and laboratory." Unfortunately, Dr. Head has been the victim of outrageous racial harassment, discrimination, and retaliation occurring within GLAHS.

Dr. Head obtained his Doctor of Medicine degree from Ohio State University, College of Medicine in 1993. Between 1992 and 1993, Dr. Head completed an Internship in Surgery at the University of Maryland at Baltimore. Between 1994 and 1996, Dr. Head commenced his employment with a Fellowship in Neuro-Otology Research at UCLA School of Medicine. Between 1996 and 1997, Dr. Head completed a Surgical Internship at UCLA School of Medicine. Between 1997 and 2002, Dr. Head worked as a Resident in the UCLA School of Medicine Head and Neck Surgery Department. In 2002, Dr. Head joined the faculty as a Visiting Professor in Head and Neck Surgery at UCLA. In 2002, Dr. Head also joined GLAHS. During his time with GLAHS, Dr. Head worked as a Head and Neck Surgeon, and in 2007, was promoted to Associate Director, Chief of Staff, Legal and Quality Assurance within GLAHA. In August 2003, Dr. Head joined the faculty of the UCLA Geffen School of Medicine as a full time Head and Neck Surgeon. Dr. Head left UCLA in 2013. Dr. Head has been board certified in Head and Neck Surgery since June 2003.

Over the years, Dr. Head's work has included clinical practice, surgery, academia, and research. Dr. Head has received accolades for his work, including the National Institute for Health National Cancer Institute Faculty Development Award. In or around 2001 to 2002, Dr. Head was nominated for the UCLA Medical Center Physician of the Year award. In or around November 2003, Dr. Head launched the UCLA Jonsson Cancer Center Tumor Lab, which has been tremendously successful, yielding valuable research and benefitting many physicians and patients at UCLA and worldwide. In 2003, Dr. Head was one of a few surgeons nationwide to receive the Faculty Development Award from the National Institute of Health Comprehensive Minority Biomedical Branch, intended to increase the number of minority physicians in cancer research at major academic institutions.

An important point relevant to this testimony includes the relationship between GLAHS and the University of California, Los An-

geles ("UCLA"). UCLA has several affiliated hospitals, one of which includes GLAHS. As part of this affiliation, UCLA provides physicians and surgeons to staff GLAHS. Until his departure from UCLA in July 2013, Dr. Head worked at both entities under this UCLA/GLAHS affiliation. [2]

Dr. Head's supervisors include Marilene Wang, M.D. ("Dr. Wang"), UCLA/GLAHS Head and Neck Surgeon and Dr. Head's immediate clinical supervisor at GLAHS; Dean Norman, M.D. ("Dr. Norman"), GLAHS Chief of Staff; Matthias Stelzner, M.D. ("Dr. Stelzner"), GLAHS Chief of Surgical Services; and Donna Beiter, RN, MSN ("Ms. Beiter"), GLAHS Director. Dr. Head's immediate supervisor at UCLA was Gerald Berke, M.D. ("Dr. Berke"), Chairman of the UCLA Department of Head and Neck Surgery, who has tremendous power and influence at GLAHS.

Discrimination and Retaliation Against Dr. Head

Despite Dr. Head's many accomplishments and contributions to the medical profession, Dr. Berke and Dr. Wang have made several inappropriate racial comments about black people, including Dr. Head. In or around 2003, Dr. Wang made comments that Dr. Head was hired as a Visiting Professor because he was an "affirmative action hire" and "affirmative action project." In or around 2003, Dr. Wang also publicly stated that Dr. Head is inferior because he is black, that he would not pass the boards, and that he was unqualified. In or around 2003, Dr. Wang stated that "cream rises to the top," that Dr. Head "would not make it in academic medicine," and that Dr. Head and "doctors like him" who are black, were the reason for failed hospitals like King Drew. In or around mid-2003, Dr. Berke stated that "we're about to have some color" in the department. Dr. Berke also stated, "I guess we'll have our first Nigger" now.

From 2003 to present, Dr. Head has lived with Dr. Wang's threats and affirmative actions to destroy Dr. Head's career, reputation, and ability to earn a living. In that regard, in 2003, Dr. Wang, who has supervisory authority over Dr. Head at GLAHS and prepared evaluations of his performance, clearly indicated it was her intention to prevent Dr. Head from receiving promotions, full time equivalents, tenure, and advancement. Dr. Wang's discriminatory conduct has been continuous and consistent throughout Dr. Head's employment.

Starting in or around 2003, Dr. Wang began stating to other surgeons that she fully intended to interfere with Dr. Head's professional advancement, in part by giving Dr. Head subpar evaluations and falsely attacking Dr. Head's credentials and performance at GLAHS.

In March 2004, Dr. Head submitted an EEO complaint outlining the discriminatory and hostile behavior against him by Dr. Wang. (A true and correct copy of this EEO complaint is attached hereto as Exhibit 1.)

In or around June 2004, Dr. Wang was ordered by UCLA officials to stop submitting negative evaluations about Dr. Head after Dr.

[2] While there may be additional information relevant to Dr. Head's testimony, because of certain conditions, Dr. Head will focus his testimony here solely on incidents related to his employment at GLAHS.

Wang was reported by Dr. Head as having called Dr. Head an "affirmative action hire," amongst other racist comments. At that time, Dr. Wang promised not to interfere with Dr. Head's career advancement. However, in direct violation of this order, Dr. Wang continued to submit negative supervisor evaluations at GLAHS regarding Dr. Head's performance, which evidenced her obvious racial bias against Dr. Head. Dr. Wang's ongoing harassment and retaliation against Dr. Head in this way continued to negatively impact Dr. Head's career advancements.

In or around November 2005, Dr. Wang gave Dr. Head a retaliatory and harassing evaluation of his teaching and performance at GLAHS in an attempt to interfere with his advancement at UCLA. Dr. Wang rated Dr. Head a 1 out of a possible 4 points in his review. Dr. Wang further wrote that Dr. Head "doesn't teach, yells at junior residents," "poor availability, doesn't respond to messages," and "poor example & role model for residents." Dr. Wang's performance review was in sharp contrast to reviews and comments made by other colleagues.

On or about February 2, 2006, Dr. Head sent a letter to Dr. Rosina Becerra ("Dr. Becerra"), then-Vice Provost for Faculty Diversity and Development at UCLA, regarding this harassment, discrimination, and related problems at UCLA and requested financial and other support to stop the harassment, retaliation, and interference with his career advancement. Dr. Head also requested that he be assigned more time working at UCLA in order to be removed from Dr. Wang's supervision at GLAHS. In response, Dr. Becerra told Dr. Head that she could not help him, and warned Dr. Head it was not a good idea to participate in an investigation against Dr. Wang.

In or around April 2006, Dr. Head was contacted for the first time by Investigator Nancy Solomon ("Investigator Solomon") of the Office of Inspector General ("OIG") regarding an investigation of Dr. Wang for time card fraud concerning work Dr. Wang performed at GLAHS. Dr. Head learned from Investigator Solomon that Dr. Wang was under investigation by the federal government for submitting and/or approving false time cards pertaining to services provided at GLAHS. Dr. Head was asked by Investigator Solomon to testify about Dr. Wang's involvement in time card fraud. Dr. Head requested protection from Investigator Solomon, stating that he feared retaliation for his participation in the investigation. With a promise by Investigator Solomon regarding protection from retaliation for his cooperation, Dr. Head testified in an OIG deposition regarding Dr. Wang's time card issues.

The OIG investigation concluded that Dr. Wang had in fact committed time card fraud. There was a recommendation by the OIG that Dr. Wang be removed from her leadership position and terminated from GLAHS; however, Dr. Wang's immediate supervisor, Dr. Berke, took steps to save Dr. Wang's job and leadership position—UCLA transferred vacation hours to Dr. Wang's account and research funds were transferred from Dr. Berke. Additionally, Dr. Berke approached Dean Norman, M.D. ("Dr. Norman"), GLAHS Chief of Staff, to request that Dr. Wang not be terminated. Due to Dr. Berke's intervention and powerful influence, Dr. Norman did not terminate Dr. Wang, did not dock her pay, and did not remove

her from her leadership position as Chief of Head and Neck Surgery at GLAHS, despite the recommendation for termination by the OIG. In fact, the only action taken was a written warning issued to Dr. Wang and termination of a subordinate.

Prior to Dr. Head's participation in the time card fraud investigation of Dr. Wang, Dr. Head had been nominated for Head and Neck Department teacher of the year. However, following Dr. Head's participation and truthful testimony in connection with Dr. Wang's time card fraud investigation in April 2006, Dr. Berke and Dr. Wang escalated their campaign of intimidation, harassment, discrimination, and retaliation against Dr. Head.

In or around April/May 2006, Dr. Head met with Dr. Berke to discuss Dr. Head's total compensation package for the academic year 2006–2007. Dr. Berke threatened Dr. Head stating, "If you complain about Dr. Wang," and about not getting the compensation enhancement (a Full-Time Equivalent ("FTE") that was available, which Dr. Wang denied Dr. Head and gave to another surgeon from outside the hospital), "you won't get anything, you'll be removed."

In or around April/May 2006, shortly after Dr. Head provided deposition testimony to the OIG, Dr. Wang discussed with the residents of the UCLA Head and Neck Department, whom she supervised and worked with, about Dr. Head's participation in the time card fraud investigation. In addition, Dr. Wang spoke with many of the residents who worked under her supervision as they each testified in the time card fraud investigation. As a result, these residents, began to participate in the intimidation, harassment, discrimination, and retaliation of Dr. Head. Dr. Head began to experience horribly offensive discriminatory comments, graphic racial photos, and retaliatory actions and statements.

In or around May 2006, Dr. Head reported to Dr. Dennis Slamon ("Dr. Slamon") that he was being harassed and retaliated against by Dr. Berke and Dr. Wang and was worried about his future. Dr. Slamon responded, "They [Dr. Berke, Dr. Wang, and Dr. Abemayor] think you ratted out Wang in the IG investigation. You need to keep your head down and stay out of this. Don't complain."

In or around May 2006, Dr. Head requested a full-time appointment at GLAHS, but did not receive the appointment despite being more qualified than other choices.

In or around June 2006, at the year-end closing ceremony and party for the UCLA Head and Neck Department—attended by approximately 200 people including UCLA and VA faculty, staff, chairs, residents, and spouses—the resident class presented a slide show. The slide show, presented by the Residents had an entire section about Dr. Head. These slides, directed toward Dr. Head, were exceptionally vulgar, disturbing, defamatory, discriminatory, retaliatory, humiliating, degrading, disgusting, demoralizing, and racist. One slide, referencing the OIG time card fraud investigation of Dr. Wang, showed Dr. Head on the telephone and read: "If all else fails call 1–800–488–VAIG." (See Exhibit 2.) The other slides throughout the presentation were similar to Dr. Wang's comments in her performance "evaluations" of Dr. Head: That he is a bad doctor, bad researcher, and bad teacher.

In or around June 2006, Dr. Head's surgical practice was restricted, and more complex surgical operating room time was being given to vastly under qualified surgeons.

In or around December 2006, Dr. Wang continued to submit false critical evaluations of Dr. Head, assigning him the lowest marks possible. Caused by her malice, personal vendetta, and discriminatory bias towards Dr. Head, Dr. Wang's false evaluations were defaming to Dr. Head's professional reputation, criticizing his competence generally and as a teacher, researcher, and mentor.

In or around early 2007, Dr. Head learned that Dr. Berke and Dr. Wang were planning on terminating Dr. Head's employment if given the opportunity. Consistent with the repeatedly expressed intention to remove Dr. Head, Dr. Berke and Dr. Wang micromanaged Dr. Head's performance, concerning trivial matters or matters that were entirely manufactured. Although Dr. Head actively and successfully thwarted Dr. Berke's and Dr. Wang's efforts to vex, annoy, and harass him into voluntarily resigning his position, Dr. Wang continued to provide negative evaluations of Dr. Head between 2007 and 2008.

In or around December 2007, Dr. Wang submitted another critical evaluation of Dr. Head giving him all 1's out of 5's. Dr. Wang made false statements such as: "Difficult to reach on pager." "No tangible research activity." "Poor role model."

On or about May 5, 2008, Dr. Wang again submitted a Teaching Evaluation—knowing it was to be submitted into Dr. Head's Promotions Packet for tenure decisions—marking all 1's (Unsatisfactory), stating "poor clinical judgment, poor availability, poor role model." (See Exhibit 3.) Dr. Wang continued to provide negative false information and evaluations about Dr. Head, despite orders to stop.

In or around July 2008, in a further attempt to harass and retaliated against Dr. Head, he was wrongfully accused of ten counts of time card fraud and lying to his supervisor.

In July 2008, Dr. Head was forced to file another EEO complaint regarding the threatening and retaliatory treatment against him by VA administrators and supervisors. (A true and correct copy of this EEO complaint is attached hereto as Exhibit 4.)

In or around August 2008, in order to further retaliate against Dr. Head, his salary was reduced. At this time, in order to undermine Dr. Head's teaching, a fee-based physician was hired in the clinic to see Dr. Head's patients at an increased cost to GLAHS.

In or around August 2008, Dr. Head was transferred to the Quality Assurance program to minimize the retaliation by management resulting from his 2004 EEO complaint.

On or about September 10, 2008, Dr. Michael Mahler ("Dr. Mahler"), Chief of Organizational Improvement at GLAHS wrote a detailed account of the harassment, discrimination, and retaliation against Dr. Head. In this letter, Dr. Head was exonerated of time card fraud. Furthermore, it was found that "Dr. Stelzner and Dr. Wang improperly treated Dr. Head differently than other members of the section." (See Exhibit 5.)

In early 2009, Dr. Head again consulted with Dr. Becerra regarding Dr. Wang's unfair and improper evaluations of Dr. Head and her treatment of Dr. Head in assignments and research opportuni-

ties. Dr. Becerra responded, "Oh my God, here we go again. I am going to legal with this." Dr. Becerra replied, "Come back to see me if you don't get tenure, otherwise you're not damaged."

In or around January 2009, in an attempt to further sabotage Dr. Head's tenure and career advancement, Dr. Wang again submitted false evaluations of Dr. Head.

On several occasions, regarding Dr. Wang's unfair treatment and improper evaluations of Dr. Head's performance, Dr. Head individually met with Dr. Gold, Dr. Rosenthal, Dr. Mechoso, and Dr. Becerra, all of whom communicated a similar message that if Dr. Head wanted tenure, he better not take any action against Dr. Wang.

In or around January 2009, Dr. Head presented to Dr. Richard H. Gold ("Dr. Gold"), Assistant Dean of Academic Affairs, a report conducted at GLAHS showing findings that Dr. Wang was biased against Dr. Head in her evaluations of his performance, assignments, and research. When Dr. Head first received this report, Dr. Head informed Dr. Berke that he had this report and could prove that Dr. Wang was treating him differently and unfairly in assignments and research opportunities. Dr. Berke offered to pay Dr. Head for the report saying, "How much do you want for the report? You can't release that report." Dr. Head replied he did not want money, he wanted to be treated fairly and to receive the tenure he deserved and had earned.

In or around October 2009, another GLAHS employee reported being transferred to another department and refused promotion for not submitting false reports against Dr. Head concerning his attendance at GLAHS.

Also around this time, prior to Dr. Norman's vacation to Fiji, Dr. Head and Dr. Norman met to discuss Dr. Head's fear of more intense retaliation and loss of income at GLAHS. Dr. Norman stated that Dr. Head would be protected with a significant salary increase; however, that increase never occurred, instead, Dr. Head endured further retaliation. On information and belief, Dr. Norman later told a faculty member on his trip to Fiji that "he really liked Dr. Marilene Wang and that they had a good relationship."

In or around September through November 2010, Dr. Head participated as a witness, and later in March through October 2011, and even through today, Dr. Head has testified on behalf of Dr. Jasmine Bowers in a racial discrimination case against GLAHS. Dr. Wang is on the peer-review panel at GLAHS and considered a witness in the Bowers Case. Immediately after Dr. Head participated in the Bowers Case, Dr. Berke, Dr. Wang, and Dr. Norman escalated the retaliation and harassment against Dr. Head.

In or around June 2011, in an effort to further discredit Dr. Head, Dr. Wang began making accusations of wrongdoing against Dr. Head. Dr. Wang stated to a group of surgeons that Dr. Wang was sure Dr. Head would not last long and that he would be investigated at GLAHS where Dr. Wang is Chief of Head and Neck Surgery.

In or around September 2011, Dr. Norman confronted Dr. Head, stating "you're a bad doctor" and wrongfully accusing Dr. Head, claiming "you're never here" and asking Dr. Head about his work

hours. Dr. Norman threatened Dr. Head stating "I'm very worried about you."

In or around October 2011, James Itamura, EEO Investigator, wrote a detailed account of the harassment, discrimination, and retaliation occurring against Dr. Head at GLAHS, which was provided to the Office of Special Counsel. (See Exhibit 6.)

On or about October 25, 2011, Dr. Head was on an emergency call at UCLA when he contacted Vishad Nabili, M.D. ("Dr. Nabili") to cover for him on an elective surgery at GLAHS. A few days later, Dr. Head learned that he was accused of not showing up for a surgical procedure, which was reported to Human Resources. Despite his promise to correct Dr. Head's time cards to correctly reflect Dr. Head's work, Dr. Norman charged Dr. Head with being Absent Without Leave ("AWOL") and reduced Dr. Head's pay approximately $7,000.

Around this time, Dr. Head was being told by co-workers that Dr. Norman was trying to push Dr. Head out of GLAHS. In or around November 2011, Dr. Joel Sercarz ("Dr. Sercarz"), fellow Head and Neck Surgeon at UCLA, informed Dr. Head that Dr. Wang told Dr. Sercarz that GLAHS was planning to "get [Dr. Head] on time card fraud." Dr. Head reported these allegations to Dr. Norman and others. In retaliation, Dr. Norman tried to restrict Dr. Head's tour of duty.

On or about November 20, 2011 Dr. Norman ordered his assistant to mark Dr. Head AWOL for 90% of the pay period. This action resulted in severe financial distress for Dr. Head, causing his house to go into foreclosure. Despite Dr. Head providing evidence showing he in fact did work his tour of duty, Dr. Norman did not turn in Dr. Head's time cards for several weeks. It was not until after Congresswoman Karen Bass and others inquired into Dr. Head's pay, that Dr. Head finally received a check.

On November 23, 2011, Dr. Head filed a formal EEO complaint.

On or about April 17, 2012, Dr. Head filed a lawsuit against the Regents of the University of California and certain individuals. The case, Christian Head, M.D. v. Regents of the University of California, et al., Case No. BC 482981, was filed in Los Angeles Superior Court. In or around July 2013, the case was settled and "The matter has been resolved to everyone's satisfaction."

On or about July 18, 2013, UCLA release a statement which read:

The Regents of the University of California and Dr. Christian Head today reached a settlement in a civil case he brought against the University last year. The case presented difficult issues of alleged discrimination and retaliation that were strongly contested.

The University acknowledges that in June 2006 during an end-of-year event, an inappropriate slide was shown. The University regrets that this occurred. The University does not admit liability, and the parties have decided that the case should be resolved with a mutual release of all legal claims. The matter was settled to the mutual satisfaction of the parties. A true and correct copy of this press release is attached hereto as Exhibit 7.)

Unfortunately, the retaliation against Dr. Head did not stop with Dr. Head himself, but spread to anyone that even attempted to support Dr. Head or provide truthful testimony on Dr. Head's be-

half. In or around June/July 2012, Dr. Jeff Suh ("Dr. Suh"), fellow Head and Neck Surgeon at UCLA, told a representative of a sinus surgery supply company not to assist Dr. Head with necessary surgical supplies or with his lawsuit or the representative would lose all business at UCLA. Around this same time, Dr. Suh also threatened Dr. Sercarz not to assist Dr. Head with his lawsuit or his complex surgical cases or he would not receive help or referred cases. Dr. Suh claimed he was speaking on behalf of Dr. Wang in regards to these threats. Because of this retaliation, Dr. Sercarz was forced to bring his own civil action to protect his name and reputation. (A true and correct copy of this civil complaint is attached hereto as Exhibit 8.)

On or about August 2, 2012, in further harassment and retaliation against Dr. Head, Dr. Wang refused to treat one of Dr. Head's patients, leaving the patient in the emergency room for days, using the patient's care and safety as a weapon against Dr. Head, creating a hostile environment and jeopardizing patient safety.

Dr. Head was one of the first to draw attention to the delay in care and the backlog of patients within the VA system. On November 16, 2012, Dr. Head sent Dr. Norman an email discussing the issue of delayed patient care at the VA. Specifically, Dr. Head informed Dr. Norman that the delayed diagnosis of cancer was a major issue facing the VA. (A true and correct copy of this email and accompanying attachments is attached hereto as Exhibit 9.)

In or around May 2014, Dr. Head learned that VA administrators had improperly taken approximately 60–100 days of sick leave time and approximately 80–90 days of vacation time from Dr. Head in retaliation for Dr. Head's protected whistleblower activity, specifically, Dr. Head's truthful testimony regarding Dr. Wang's illegal time card fraud, testimony in support of Dr. Bowers's racial discrimination case, and reports of delayed care and backlog of veterans within the VA system. Less than two months ago, administrators within GLAHS retroactively took these accrued time-off days, falsely claiming that Dr. Head had previously failed to enter his time.

Retaliation against other whistleblowers, because of Dr. Head's leadership position within glahs and his willingness to stand up against wrongdoers within the system, dr. head has become aware of many other VA employees who are enduring their own retaliation.

Incident 1:

One instance involved a 53-year-old African American woman, Dr. Jasmine Bowers ("Dr. Bowers"), who is a board-certified anesthesiologist and has practiced in anesthesia and pain management for over 24 years.

In May 2010, Dr. Bowers was offered a per-diem, fee-basis position, which was an hourly position with capped weekly hours, and no benefits. Because of the dire need for anesthesiologists at the VA, Dr. Michelle Braunfeld ("Dr. Braunfeld"), chief of anesthesiology, assured Dr. Bowers that the appointment would likely last longer than a year. When Dr. Bowers inquired about full-time positions, Dr. Braunfeld stated that the only available position was for an acute pain specialist. Having her fellowship in pain manage-

ment, and more than twenty years of experience in the field, Dr. Bowers expressed interest in the position. Dr. Braunfeld was dismissive, and stated Dr. Bowers would likely have to have board certification in pain management to be hired for the position. Unbeknownst to Dr. Bowers, Dr. Braunfeld had advertised for a "general anesthesiologist" position in May 2010. In addition, at or around the same time Dr. Bowers was hired (in June 2010), Dr. Braunfeld offered a full-time, FTE anesthesiologist position to Dr. Corey Downs ("Dr. Downs"), who began working at the VA in approximately July 2010. Dr. Downs was fresh out of his residency at UCLA, and was not board certified in anesthesia. Dr. Bowers began her fee-basis appointment on or about July 6, 2010, but continued to make inquiries regarding a full-time FTE position. At one point in her employment, Dr. Bowers overheard Dr. Braunfeld stating to someone else, "We can't hire certain people for full time jobs because it's too hard to get rid of them."

After beginning her fee-basis position, Dr. Bowers began to experience demeaning and disrespectful conduct from the certified nurse anesthetists ("CRNAs") at the VA. The harassment began with relatively minor incidents, including several CRNAs referring to her by her first name, and one particular CRNA, Krista Douglas ("Douglas") making a rude comment in the CRNA lounge. Douglas and other CRNAs reprimanded Dr. Bowers in front of others, including patients, and were consistently treating her with disdain and disrespect. In over 24 years of practice working with nurses and CRNAs without such issues, Dr. Bowers decided to speak to the lead CRNA, Dana Grogan ("Grogan") and Dr. Braunfeld about her concerns. After she complained, the harassment escalated. Douglas refrained from speaking to her altogether, and refused to relieve her during surgeries, in spite of her duty to do so. On one occasion, Dr. Bowers had a conversation with a man working at an administrative desk in the surgery department, Terry Woods ("Woods"), and mentioned her issues with Douglas. Woods told her that Douglas had treated another African American anesthesiologist in a similar manner, and told Dr. Bowers to "watch her back."

Following a surgery on September 14, 2010 in which Dr. Bowers administered anesthesia, Grogan went to Dr. Braunfeld with printouts from the blood pressure monitor ("strips") from the surgery, and the intra-operative anesthesia one-page report, but not the patient's chart. Grogan claimed that she went to Dr. Braunfeld to report her concerns about the patient's low blood pressure and what she found to be discrepancies between the handwritten chart and the blood pressure monitor strips. Dr. Braunfeld then went to Dr. Stelzner with her concerns, and then went to the Chief of Staff, Dr. Norman. Dr. Braunfeld later stated that she discussed her concerns with Dr. Norman and that they agreed to remove Dr. Bowers from the September schedule, and investigate the matter. Dr. Norman told Dr. Braunfeld to obtain a written response from Dr. Bowers. At the end of that day, and after Dr. Bowers was allowed to administer anesthesia all day, Dr. Braunfeld brought Dr. Bowers into her office and accused her of falsifying medical records and allowing a patient to remain hypotensive for 45 minutes during the surgery, essentially endangering the patient. Dr. Braunfeld told her she would not be allowed to return to work, pending an investigation,

and did not ask Dr. Bowers to provide any written response. Dr. Bowers asked to be allowed to provide a written response, which she did on September 20, 2010. In her response, Dr. Bowers requested an independent, administrative review of the case, and expressed that she was shocked and upset at being accused of misconduct, especially in light of the fact that the surgery had no complications and was successful.

The VA obtained a report from Dr. Nitin Shah ("Dr. Shah") who is an expert, author, professor, and anesthesiologist at the Long Beach VA. On November 2, 2010, Dr. Shah spoke with Dr. Mahler, deputy Chief of Staff and head of Risk Management about his findings. Dr. Shah stated that while there were some discrepancies between the hand-written chart and the monitor strips, he did not believe there was any misconduct in charting. He also found no negligence, nor patient endangerment, by Dr. Bowers, in light of the patient's history of low blood pressure, and successful outcome of the surgery with no complications. Dr. Shah expressed that he was troubled by Grogan's failure to mention her purported "concerns" during the surgery to her supervising anesthesiologist or to the surgeon. Although instructed by the VA not to comment on the standard of care, Dr. Shah submitted a report on November 4, 2010, with his findings. He stated that out of 16 blood pressure chart entries, 7 attributed to Dr. Bowers were inconsistent with the monitor readings. He stated that this may be the result of "sloppiness," but not misconduct. He also stated that discrepancies in charting do occasionally happen when the anesthesiologist is managing other aspects of the patient's care. He reiterated his determination that there was no patient endangerment in the management of the patient's blood pressure by Dr. Bowers during the surgery.

Dr. Head, in his role as head of Quality Assurance, reviewed the patient's charts and records. He spoke with the surgeon, the resident who participated in the surgery, the supervising anesthesiologist, and the CRNA and Dr. Raj who started the case. After determining there was no issue with the patient's low blood pressure, he told Dr. Norman and Dr. Mahler that he was troubled with the manner in which Dr. Bowers was being treated. Dr. Head also heard other medical staff discussing the case, and people stating that Dr. Bowers had "almost killed a patient." This was determined to have started with Grogan, and Dr. Head heard the same comment from Sandra Riley-Graves, an administrative assistant in Dr. Norman's office. Shortly after discussing his findings with Dr. Norman, Dr. Head overheard Riley-Graves state, "It's a black thing" to Dr. Mahler, implying that Dr. Head was supporting Dr. Bowers because he was also African American. After he heard Dr. Mahler yelling at Riley-Graves behind the closed office door, Dr. Mahler came out of the office and told Dr. Head to "stand down" on the investigation and leave it alone.

Dr. Braunfeld never contacted Dr. Bowers again, and never provided Dr. Shah's report to Dr. Bowers. In spite of Dr. Shah's favorable review, that there was no negligence, misconduct, or patient endangerment, Dr. Bowers was never reinstated or placed back on the schedule.

Shortly after Dr. Bowers initiated the EEO process, Congresswoman Diane Watson wrote to Donna Beiter ("Beiter"), Director and CEO of the VA, with her concerns and questions about ongoing discrimination at the VA. The VA's response to Congresswoman Watson contains inconsistencies. For example, Beiter stated that Dr. Bowers never provided a response to the allegations, which was false.

Dr. Bowers initially contacted the EEO office on September 30, 2010. The EEO Office issued a Notice of Acceptance. After conducting its investigation, the EEO's assigned investigator, James Itamura, concluded that a culture of racial and age discrimination exists in the anesthesiology department at the VA, wherefrom Dr. Bowers and other older and non-white anesthesiologists were removed in order to make room for younger replacements from UCLA.

Incident 2:

Dr. Saroja Rajashekara (commonly referred to as "Dr. Raj") was a cardiac anesthesiologist at the VA from 2002 to 2011. Dr. Raj reported to the EEO Investigator she observed and experienced age discrimination at the VA. While she was initially hired by then-Chief of Anesthesia, Richard Chen, Dr. Raj worked under Dr. Braunfeld after she became Chief of Anesthesia in January 2010. After her mother became ill in early 2010, Dr. Raj took leave (which was approved) to visit her mother in India. While she initially expected to return in early May, she sent correspondence to Dr. Braunfeld stating that she needed to extend her leave. Dr. Braunfeld contacted the HR Department at the VA asking how to deem Dr. Raj AWOL. In Dr. Braunfeld's correspondence with HR, she lied about her prior contact and correspondence with Dr. Raj. As a result, Dr. Raj was considered "AWOL" and was removed from the cardiac schedule. She ultimately provided evidence of her contact with Dr. Braunfeld, and the AWOL status was removed from her personnel file; however, Dr. Braunfeld did not reinstate her on the cardiac schedule. Instead, Dr. Braunfeld had her replaced with younger UCLA graduates, who were far less qualified, with the knowledge and approval of Chief of Staff, Dr. Norman.

Dr. Raj reported to the EEO Investigator her concerns regarding Dr. Bowers's treatment by the VA. (See Exhibit 10.) She was aware that there was a need for anesthesiologists at the time of Dr. Bowers's hire at the VA, but Dr. Braunfeld was "holding" jobs for younger, less-qualified residents from UCLA. Dr. Raj also remarked about the unusual manner in which Dr. Bowers was immediately removed from the schedule following the September 14, 2010 surgery. Specifically, she stated it was not the typical protocol for a case such as Dr. Bowers's to bypass the Quality Assurance process, and that Dr. Bowers was "fired" in spite of the patient having no complications.

Incident 3:

Dr. Carol Bennett, an African American woman, has worked at the VA for over 15 years and is currently the Chief of Urology. Dr. Bennett filed an EEO complaint against Dr. Stelzner and Dr. Norman in 2005 based on race discrimination. Dr. Bennett was discovered to have been allowing her nurse to use her CPRS code to sign

off on prescriptions on the electronic chart, albeit with her full knowledge and consent. On August 24, 2005, she received a letter from Dr. Stelzner advising her that she was placed on administrative leave. Dr. Bennett was immediately taken off duty without an investigation. She admitted to Dr. Stelzner her mistake, but that it was common practice among surgeons in order to move on to the next patient. All of the entries were with the surgeons' knowledge, and they would review and sign the chart later. In her EEO complaint, Dr. Bennett addressed the fact that another non-African American physician was found to have a similar infraction, but was only given warnings. She also complained that she was being "super-audited" by Dr. Stelzner, as compared to other non-African American medical staff in the Department of Surgery. After mediation, Dr. Bennett was fully reinstated as Chief of Urology.

Incident 4:

In another instance, an employee working as an EEO Counselor in the Office of Resolution Management was retaliated and terminated for making a protected whistleblower complaint. This employee, considered to be one of the top EEO counselors in the nation, filed a report to internal investigators regarding missing EEO files which contained private personnel information of specific VA employees. Because this employee's report reflected negatively on his supervisor, Ms. Tracy Strub, Ms. Strub retaliated against the employee, initiating an unjustified Performance Improvement Plan.

In or around July 2013, shortly after Dr. Head settled his lawsuit with UCLA, VA administrators questioned this employee about whether or not this employee had helped Dr. Head with his lawsuit. This employee denied that he had helped Dr. Head, but because of this employees close relationship with Dr. Head, VA administrators did not believe him. Within hours of this meeting, the employee was terminated.

Incident 5:

In another instance, Dr. Wang discriminated against a Nurse Practitioner working in the Head and Neck Department at the VA based on her national origin and Muslim faith. After seeing this employee working with Dr. Head, Dr. Wang also told this employee not to work with Dr. Head or provide him any assistance with patient care. Because of Dr. Wang's discriminatory animus towards this employee, as well as continued retaliation against Dr. Head, Dr. Wang had the employee terminated the day before her probationary period ended.

Incident 6:

In a recent incident, an OR tech complained to VA management about dangerous conditions in the operating rooms, specifically, surgeons using dirty instruments while operating on patients. Following this report, this employee was given both verbal and written reprimands. Recently, the employee was suspended for 14 days for making these complaints.

Climate of fear and retaliation within the GLAHS: As outlined above in detail, administration within GLAHS has created a climate of fear and intimidation, where the system not only fails to protect whistleblowers, but actively seeks to retaliate against them.

This retaliation by VA supervisors and administrators often takes shape through a similar process.

Whistleblowers are first threatened and isolated, often being warned early that speaking out would not be beneficial to their career. Whistleblowers are made aware, in no uncertain terms, that if you tell the truth, you will be punished.

If the whistleblower chooses to speak out despite the threats, they are quickly defamed and humiliated. Supervisors and administrators will begin spreading false information about the whistleblower, suggesting to co-workers that the person is incompetent, lazy, and untrustworthy.

Finally, supervisors place the whistleblower under intense scrutiny, looking for any reason to find fault in the person's work. Whistleblowers, who otherwise have had long, outstanding careers within the federal system, all of a sudden are subpar workers who begin receiving failing evaluations, verbal and written reprimands, salary cuts, transfers, demotions, and sometimes even being forced to retire, or worse, terminated. Even those in high administration within GLAHS that attempt to do the right thing are not safe. For example, Dr. Mahler, former deputy Chief of Staff and head of Risk Management, who provided a written statement in support of Dr. Head, was eventually forced out.

Administrators and supervisors with GLAHS have created a toxic environment with a clear message, if you do not follow the agenda and behave as a "team player," you will suffer the consequences.

Lack of accountability: The current system within the VA is one of a general lack of accountability of administrators and supervisors who actively retaliate against and ostracize hospital employees who attempt to speak out against illegal behavior. This climate only perpetuates this illegal behavior, due in large part to the system's failure to take any action against certain individuals. Specifically, wrongdoers are left in positions of high leadership to continue their illegal behavior without recourse. In some circumstances, wrongdoers may even be promoted rather than disciplined.

For example, the investigation regarding Dr. Wang led to a finding that Dr. Wang had committed time card fraud during a certain period of time in her leadership position at GLAHS. However, rather than being disciplined, Dr. Wang was instead promoted. Even worse, Dr. Head then was retaliated for providing truthful testimony in Dr. Wang's time card fraud investigation.

Leaders within GLAHS, such as Ms. Beiter and Dr. Norman, not only have played an active role in retaliating against whistleblowers, but in other cases have chosen to ignore certain occasions of retaliation by GLAHS supervisors. Ms. Beiter and Dr. Norman have had many opportunities to take action against wrongdoers, but have chosen instead to look the other way.

Low morale amongst healthcare providers: Unfortunately, the current climate of fear and retaliation, coupled with the system's failure to properly respond and hold wrongdoers accountable, has caused morale to be dangerously low, leaving employees within GLAHS with a sense of helplessness, creating undue stress and

anxiety amongst those attempting to provide quality healthcare to our Country's veterans.

Dr. Head has witnessed a general sense of fear amongst VA employees. Workers within GLAHS have stated that they are scared to speak out for fear of being blamed and punished. Good people who are used to doing the right thing and standing up for others want to speak out about issues throughout the system, but fail to do so for fear of jeopardizing their careers.

Negative affect on patient care: The issue facing the VA system involves a growing epidemic in hospitals throughout our Country—hospital bullying. This issue spans race, gender, religion, and politics because of the life and death danger it poses to patients. This problem, while certainly applicable to the VA system, is an issue that plagues every hospital nationwide and must eventually be addressed by Congress.

In her MSNBC article, Hospital Bullies Take a Toll on Patient Safety, JoNel Aleccia outlines how hospital bullying "threatens patient safety and has become so ingrained in health care that it's rarely talked about." (Exhibit 11.) Additionally, in Dr. Kevin Pho's article for FoxNews entitled Bullies in Hospitals?, he concluded that "targeting the toxic culture that perpetuates the problem [of hospital bullying] requires everyone to share responsibility. Not just doctors, but nurses, hospital administration, and medical educators as well. Only when every stakeholder is part of the solution do we stand a better chance of eliminating bullying behavior in hospitals altogether." (Exhibit 12.) Dr. Pho's article was a response to a highly-touted New York Times article by Theresa Brown entitled Physician, Heel Thyself, in which she detailed bullying behavior she experienced as a nurse and explained how hospital bullying poses a critical problem for patient safety which, not surprisingly, leads to a rise in medical errors. (Exhibit 13.)

Of course, all of these articles came after The Joint Commission published Sentinel Event Alert, Issue 40, on July 9, 2008 which described how:

Intimidating and disruptive behaviors can foster medical errors, . . . contribute to poor patient satisfaction and to preventable adverse outcomes, . . . increase the cost of care, . . . and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. . . . Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team. (Exhibit 14.)

Unfortunately, health care organizations have not addressed the problem, and doctors, nurses, and hospital administrators are left to bully and belittle others; and sadly, anyone who dares speak out about this behavior threatens not only their job, but their entire career in the healthcare profession.

Possible solutions: While this testimony has focused on current problems within the VA system, all hope is not lost. The mission of the VA system is good and noble and should be maintained. The VA system has some of the best healthcare providers in the world;

however, certain changes must be considered. There are a number of possible solutions that can be implemented to affect change and improve the system.

The first, and obvious, solution is one of leadership. Administrators and supervisors within the VA system that are contributing to the current culture must be held accountable. New leadership must be established—leaders who will encourage and welcome open discussion and dialogue, leaders who will root out divisive and intimidating behavior, and leaders who will create a safe and enjoyable atmosphere that focuses on top-quality patient care for our veterans.

Another important improvement to the system would involve a change in the appointment scheduling of veterans. Rather than the current process of adding patients to a long list based on when the person calls for an appointment, patients need to be assigned appointments based on conditions. There is a Standard Operating Procedure ("SOP") in place that could be updated and implemented which would greatly improve patient scheduling. Based on SOP flowcharts, schedulers would be able to schedule more critically ill patients sooner, ensuring every veteran receives the proper healthcare he/she deserves.

Additionally, there needs to be some type of computer accountability process implemented. Currently, the computer records can be too easily manipulated to hide scheduling and patient backlog issues. Hospital administrators should not be able to clear patient information unchecked. Perhaps some type of centralized data collection can be created to ensure individual hospitals are not fraudulently changing records.

Finally, the current proposal of simply assigning more patients to already overwhelmed physicians is not the answer. The system desperately needs to add additional primary care physicians. Then, veterans should be matched up to one specific primary care physician. This would allow the physician to establish a relationship with the patient and would create a vested interest with that physician who would then be more inclined to ensure his/her patient received proper medical care. That way, if the physician's patient is not receiving the needed care, that primary care physician would do what private practice physicians do and call his/her colleagues and follow up. For example, Dr. Head's wife, who is an interventional radiologist within the VA system, is deeply vesting in each of her patient's healthcare and does what is needed to ensure her patients are receiving the proper health services.

Dr. Head provides this testimony with the hopes of finding solutions to address employee mistreatment and improve the quality of healthcare provided to our Country's veterans. As a long time employee within the VA healthcare system, Dr. Head is optimistic that appropriate changes can be implemented, and he looks forward to being an integral part of that change and the bright future that is ahead.

Dated: October 31, 2014

CHRISTIAN HEAD, M.D.

For additional information, you may contact Dr. Christian Head through his attorneys:

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PREPARED STATEMENT OF DR. MITCHELL

Dedication

This written testimony is respectfully submitted in memory of my uncles:

Capt. Jay Anderson Mitchell, a good-natured, red-haired, blue-eyed, freckle-faced young Marine, husband, and father who lost his life & crew in 1967 when his helicopter shook apart over the South China Sea because the U.S. government failed to timely investigate the safety deficiencies of that aircraft type, and Phillip V. Mitchell, a former Institute of Defense Analyses employee and Army Veteran who moved heaven & earth within the Pentagon to ground and repair the remaining faulty helicopters in the days that followed Uncle Jay's death so other young Marines would have a chance of returning home alive to their families.

CONTENT SUMMARY

SECTION I: Introduction & Background

My name is Dr. Katherine Mitchell. I am an internist who is fellowship trained in geriatrics. My various positions caring for the Phoenix VA Veteran population have given me a great sense of personal pride during my 5 years as a registered nurse on the hospital wards, my 9.5 years as a physician within the Emergency Depart-

ment, and my 1.5 years as medical director of the Post Deployment Clinic.

I greatly admire my fellow VA employees, past and present, who have spent years trying to meet the VA mission despite facility politics, low pay, lack of resources, and the barrage of negative publicity that often overshadows the vast amounts of amazing care we have provided to countless Veterans through millions of high quality patient encounters.

Like other Phoenix VA employees, I have diligently worked within the system to identify and resolve numerous care issues and system deficiencies slowing the provision of care to Veterans. I have rewritten policies, served on committees, developed action plans, participated in Lean Teams, and composed endless emails in the pursuit of better care. Along with a huge number of other VA personnel, I have spent untold hours each pay period trying to meet work responsibilities which cannot be humanly completed within the space of the designated 40 hour workweek.

It is a great honor and pleasure to work with the many experienced VA employees who, though they could find private sector jobs with better working conditions, remain dedicated to providing and enhancing the quality of Veteran health care. Their combined expertise is vital to advancing the future of the Department of Veterans Affairs.

It is imperative for us to join together and address the longstanding series of crises within our VA that are currently threatening the viability of our institution and undermining its ability to meet and exceed our obligations to the nation's current and future Veterans.

SECTION II: Executive Summary

In the last 75 years, the VA institutional culture has descended into a breeding ground for horizontal violence within the workplace. While overt acts of physical aggression are extreme examples, VA horizontal workplace violence includes, but is not limited to, open ridicule, shouting, failure to promote for merit, inappropriate down-grading of proficiencies, unfair distribution of workload, political back-biting, and formation of, as well as exclusion from, influential workplace cliques.

Such horizontal violence has propagated in response to high stress levels, unequal distribution of power, disparate advancement opportunities, and unreasonable performance expectations. The destructive phenomenon of this internal violence has greatly eroded the quality of patient care throughout the VA system to the point that the VA has been unable to fulfill its mission to "care for him who has borne the battle . . . " for hundreds of thousands of Veterans.

In unscrupulous VA health care administrators' hands, horizontal violence has been wielded as a specific tool to advance the administrators' personal and financial goals to the detriment of quality Veteran care and system efficiency. By directly propagating horizontal violence or by ignoring the presence of it among employee ranks, VA administration has betrayed the VA core values of integrity, commitment, advocacy, respect, and excellence.

As a 16 year Phoenix VA employee who has routinely advocated for patient care improvements, I have been the recipient of horizontal violence at my facility for years. I have personally witnessed the devastating consequences such horizontal violence has wreaked on the quality of patient care within the Emergency Department.

The purpose of this written testimony is to clearly describe the details of those experiences and provide a description of administrators' tactics of retaliation against others within the Phoenix VA Medical Center and elsewhere at sister facilities.

Although improvements in overall care have propelled the Phoenix VA to a level of care significantly greater than what I observed in 1989 when I first jointed the facility, regretfully there has been no significant change in the dysfunctional institutional culture of the Phoenix VA Medical Center. Employees today still risk backlash for bringing up patient care problems, identifying misuse of facility resources, and questioning the presence of prohibited personnel practices.

Quite simply, a problem isn't allowed to exist within the Phoenix VA care system unless senior administrators officially allow it to be recognized. No matter how critical the issue is to patient care or safety, senior officials will deliberately avoid the problem by covering up any evidence of deficiency. This routinely is accomplished by ignoring legitimate requests for resources, manipulating statistics, hiding objective reports critical of the local VA's operations, and providing misleading information to outside official inquiries. Most pointedly, certain employees systematically intimidate any fellow employee who dares advocate for Veterans in a manner inconsistent with the Phoenix VA administration's party line.

Ethics have never been made an official VA performance measure, and thus do not appear to be a clear administrative goal. There seems to be no perceived financial advantage to pursuing ethical conduct. Administrative repercussions are lacking for unethical behaviors that are so routinely practiced among senior executive service employees. Unfortunately, Phoenix administration has had a financial incentive to artificially maintain a positive public image using retaliation tactics even if such a facade comes at the expense of quality patient care provision and the inability to attract and/or retain quality employees.

The most serious retaliation against me occurred during my last 3 years as the sole ER medical co-director. During that time, our ER remained greatly understaffed in terms of nurses, physicians, and ancillary employees. New graduate nurses were filling in for seasoned triage nurses. There were insufficient personnel to wash beds, answer phones, transport patients or labs, and perform other tasks. The ER physicians and nursing staff continually were pulled away from direct patient care to absorb those extra duties in order to keep the ER flowing.

As the number of patient ER visits greatly increased beginning in 2010, deficiencies in our ability to meet high standards of health care became readily apparent. In our tiny 8-room ER, even the most experienced triage nurses could not have kept up with the dangerous flood of patients diluting triage time. The number of actual or potential misses in nursing triage sky-rocketed. Internal head bleeding, strokes, heart attacks, pneumonias, and dehydration

were examples of cases missed by either inexperienced triage nurses or seasoned nurses overwhelmed by the glut of patients engulfing the ER.

Without targeting any nurse, I began reporting actual or potential misses to the nursing chain of command. As backlash from a few nurses became evident, I had to ask all physicians to give me their cases to report. I knew I had to be the only backlash target. Any large scale adversarial relationship between physicians and nurses would grind patient care to a halt during a time when we were already gasping from insufficient resources.

After reporting hundreds of cases, eventually about 20% of the ER nurses actively began to impede care of my own ER patients. Those nurses stopped initiating protocol orders for me, providing me with verbal patient reports, handing me EKGs, and answering basic questions I asked.

Although my immediate supervisor provided support to the degree the VA culture allowed, senior executives chose not to intervene to stop or investigate the horizontal violence against me. I was accused of poor communication skills. I was banned from submitting cases to the risk manager. I worked 2 years of unlimited scheduled shifts without compensation in order to keep my position as medical co-director and provide even bare bones physician staffing. My yearly proficiencies dropped. I was subjected to verbal abuse from senior executives. Human Resources failed to expedite requests for physician hiring. Eventually I would be involuntarily transferred to a medical director position in a defunct medical clinic without receiving a valid reason for such a transfer.

Staffing was increased after I was removed from the ER. Additional resources were provided including additional patient rooms. Triage was expanded. However, the intense, recurring nurse triage training for which I advocated would never be instituted.

With few avenues for change left open to me, in 2013 I submitted a 30+ page confidential OIG report through my senator's office outlining a variety of patient safety concerns & facility deficiencies. I was subsequently placed on administrative leave for a month, investigated for improper conduct, and eventually received a written counseling for violating a patient privacy policy which the Phoenix HR department still declines to name.

I remain very concerned for the future of our Veterans and the Phoenix VAMC.

The Veterans who present in Arizona for VA care have survived campaigns like D–Day, Iwo Jima, Heartbreak Ridge, Pork Chop Hill, Chosin Reservoir, Inchon Landing, multiple Tet Offensives and Counter-Offensives, Desert Storm, Kosovo, Croatia, Ethiopia, the Battle of Fallujah, and dismal years in Helmand Province. It is a bitter irony that our VA cannot guarantee their high quality health care and safety inside our medical facility in the middle of cosmopolitan Phoenix. This tragedy is no doubt mirrored in other VA facilities across the country.

This country's founding fathers organized government into 3 branches so that no one department would possess the majority of power. Eventually cabinets and departments would be created to help fulfill the obligations of the federal government to its citizens. President Lincoln conceived the VA mission eloquently as "to care

for him who have born the battle and his widow and his orphan". Sometime in the last 75 years, the Department of the VA has evolved into a powerful, narcissistic, unethical bureaucracy which at times openly defies the laws of the land including federal employment law, flouts congressional authority by ignoring requests for information, and jeopardizes the health of Veterans by statistical indiscretions.

There must be swift congressional bipartisan effort to address the gross misconduct within the VA. Congress must ensure those unscrupulous administrators who ignored ethical standards and sacrificed patient well-being for financial gain or personal prestige face consequences for unethical and/or illegal behaviors. In addition, steps must be taken to protect those employees truly devoted to patient care who found themselves in the untenable position of following orders or risk losing their livelihoods and their ability to provide any services to Veterans within the system.

With proper reforms, the horizontal violence within the VA can be stopped. VA employees will then be free to voice concerns without fear of retaliation. It is only with the combined efforts and voices of our current dedicated VA employees that the Department of Veterans Affairs will be able to evolve from a bureaucratic institution today into a dynamic health care model for tomorrow.

Most importantly, in this process, the ability to positively influence patient care and safety should not be misconstrued as being a specific Democratic or Republican platform, a pro-union or anti-union choice, or even a uniquely American problem. The ability to freely advocate for the health and safety of any patient is a human issue with ethical implications for all societies

SECTION III Phoenix VA Administrative Retaliation: Personal Experiences and Clinical Implications

Note: Because whistle-blowing retaliation in my facility is currently being investigated, I cannot include of the names of the employees or the specific documents to which I refer. These omissions are necessary to maintain the integrity of the whistle-blower investigation and also prevent potential retaliation against my co-workers.

In the last 75 years, the VA institutional culture has descended into a breeding ground for horizontal violence within the workplace. While overt acts of physical aggression are extreme examples, VA horizontal workplace violence includes, but is not limited to, open ridicule, failure to promote for merit, inappropriate downgrading of proficiencies, unfair distribution of workload, dangerous work hour requirements, political back-biting, and formation of, as well as exclusion from, influential workplace cliques. Such horizontal violence has propagated in response to high stress levels, unequal distribution of power, disparate advancement opportunities, and unreasonable performance expectations.

In unscrupulous VA health care administrators' hands, horizontal violence has been wielded as a specific tool to advance the administrators' personal and financial goals to the detriment of quality Veteran care and VA efficiency. Horizontal violence is commonly used by many supervisors to ensure compliance with their personal agendas which are disconnected from the mission and

stated values of the Department of Veterans Affairs. Administrators' retaliatory tactics essentially debase employees and suppress any identification of system deficiencies that would make the administration look unfavorable if the deficiency was openly identified.

As a 16 year Phoenix VA employee, I have seen what happens to personnel who advocate for patient safety and welfare in a manner that challenges the administrative status quo. The devastation of the individual's career is usually the end result and likely is the only transparent process that exists within the Phoenix VA Medical Center today.

During the last 3 years that I served as the sole medical co-director of the Phoenix VA Emergency Department, I routinely suffered negative workplace consequences for persistently reporting issues related to drastically inadequate staffing, lack of sufficient training, and lack of ancillary resources. After I was involuntarily transferred to the Post-Deployment medical director position in December 2012, the administration's retaliation tactics against me persisted into 2014.

Because I am a practicing physician, such retaliation greatly impeded my ability to provide high quality care for patients presenting to the ER and crippled my ability to serve as an advocate for patient health and safety throughout the VA system. The following details some instances of administrative retaliation toward me during the timeframe from 2009–2014 and the consequences to patient care.

1. Phoenix VA ER background.

I was a Phoenix VA emergency department staff physician from 2003 to approximately 2006 and then promoted to medical co-director of the ER from 2006–2009. After administration failed to fill the co-director position when my fellow co-director resigned to attend fellowship training, I remained as the sole co-director from 2009–12–10–12. Because the co-director position was never filled, I was referred to as the ER medical director by default even though the position was technically designated for two medical co-directors.

2. Despite spending 3 years repeatedly alerting senior administration to the dangerous clinical situations in the Phoenix VA Emergency Department, my concerns were ignored repeatedly by Phoenix senior administration.

Since 2009, I had been very vocal about the escalating danger to patient care in the ER because of physician shortages, nurse short-staffing, and lack of formal training for triage nurses. As a matter of habit, I notified the nursing chain of command with concerns as well as communicated the issues to staff in the physician chain of command.

When reporting morbidity (illness) and mortality (death) related to lack of quality triage, I never targeted a specific nurse. Instead, cases were used to emphasize the need for formal, ongoing nursing triage training as well as additional nursing staff.

From 2010 to 2011, I was involved in two "lean teams" (system redesign teams) to exam ER process issues affecting the quality and efficiency of the Emergency Department. Both teams concluded that the influx of new resources including additional manpower

and formal nurse triage training were necessary to help resolve care issues and correct serious flow inefficiencies.

Unfortunately, although the Phoenix VA administration did make some changes in availability of ancillary/non-medical staff, senior administration did not directly address those poor quality triage issues nor quickly resolve the ER nursing/physician shortage. Although a few nurses were sent for formal triage training in early 2012, there was never any comprehensive nurse triage training implemented despite repeated episodes of the same nursing triage patient care mistakes being made.

While on paper there were some gains in ER nursing staffing, those gains were offset by the loss of extremely experienced nurses who chose to leave the ER because of the unsafe working conditions. An increase in full-time physician manpower (above 6 full time physician positions) was extremely slow in coming. The significant understaffing of physicians in the Phoenix ER was not corrected until early 2013

Although senior officials may contend the Emergency Severity Index (ESI) was the "standard training" required for nursing triage training, ESI is only a classification system based on ER resources used. It is not a nursing-based assessment of potential complaints presenting to the Emergency Department. It does not teach nurses how to stratify potential symptoms to determine the patient's proper level of acuity (severity of health impairment).

Senior Phoenix VA administration has claimed the quality of nursing triage has significantly improved since 2012 after hiring of experienced triage nurses from the community. However, VA staff members continue to tell me anecdotally the triage process is still extremely variable. This variability increases the risk of mistakes and near-misses in ER triage.

During the years I was in the ER, there were countless instances when the lives of Veterans were needlessly placed in jeopardy because of Phoenix VA administration's lack of response to clearly identified deficiencies within the ER including lack of sufficient triage training and resources. The following cases are a few examples when appropriate care was not expedited for Veterans:

(a) A patient with homicidal thoughts and potential gastrointestinal bleeding was put in a room for 49 minutes with no report given to a physician. A patient like this is at risk for extreme violence as well as severe blood loss.

(b) Two patients were discovered to have bleeding inside their heads after sitting in the lobby for several hours. They had to be transferred out immediately for stat neurosurgery.

(c) An elderly patient with an elevated pulse rate of 119, nausea/vomiting, and abdominal pain was deemed stable for the lobby even though his presentation indicated severe illness.

(d) A patient on a blood thinner who reported dark red blood in stool was deemed stable for the lobby. This patient was potentially at risk for severe blood loss.

(e) An obviously ill, immunosuppressed patient was neglected for 5 hours before report was given to a physician.

(f) A patient with possible heart attack had no mandatory protocol orders initiated by nursing staff.

(g) No protocol lab orders initiated for an immunosuppressed patient on a blood thinner who had fallen and reported feeling lightheaded and weak.

(h) A diabetic patient with a fast heart rate of 110 who was breathing rapidly was placed in the lobby instead of being brought to the attention of the physician on duty.

(i) A patient with low blood pressure and a heart rate of 130 at rest was left to wait in the lobby for 10 hours before a physician was notified. This patient was very ill.

3. I was verbally banned from submitting cases to the Risk Manager/Patient Safety Office by a former Senior Executive Service administrator and well as by others who remain at the Phoenix VAMC.

Frustrated by the nursing service's inability to stem the issues related to nursing triage and understaffing, I submitted several concerning cases to the Risk Management department in 2011. When I checked on the status of those cases, I was informed that the cases would not be investigated. I learned the department had been told by Phoenix senior executives not to investigate my cases nor accept any future cases from me. This is contrary to both local and national VA policies which were designed to identify and address potential health and safety issues through the use of risk management reviews.

4. In 2011 & 2012 I was forced to work unlimited scheduled shifts to prevent job loss and to provide at least minimal physician staffing coverage in the ER.

When jobs were offered to ER physician candidates, Human Resources was so slow at credentialing them that those ER physicians eventually obtained employment elsewhere. Phoenix VA administrators then developed a plan to compensate for the VA's unsuccessful attempts at ER physician recruiting efforts. This plan involved having salaried ER physicians work without compensation to fill any open, scheduled shifts.

To remain a salaried medical co-director, I was informed I would have to work all scheduled, unfilled shifts myself or convince my colleagues to work the shifts without compensation. I believed forcing ER physicians to work additional scheduled shifts was not safe or ethical unless there was a facility-wide emergency declared. I stated I legally couldn't schedule any physicians for more than 80 hours per 2 week pay period. In response, I was informed that the Human Resources department had investigated and determined current physician contracts allowed the unlimited scheduling of any physician.

I had no choice but to work open unlimited shifts in order to keep my position and provide at least minimum physician staffing coverage in the ER. I knew if I refused to work those open shifts, my work environment would become more hostile from senior management. I hoped HR would expedite ER physician hiring as I was promised it would during that meeting.

Unfortunately, HR never expedited the recruitment or hiring of additional ER physicians until late 2012/early 2013. Because I worked so many open shifts, the amount spent on fee basis (hourly) ER physicians in 2011 and 2012 significantly dropped prior to hir-

ing any full-time physicians. At one point, I was physically present working various hours in the ER for 18+ days in a row to cover open shifts/short staffing. The physical and emotional strain on me was tremendous. Although administration seemed indifferent to the consequences of forced excessive work hours, I knew being forced to work abnormally long workweeks greatly increased the risk of patient care mistakes.

5. I was ordered to cut fee basis (hourly) physicians even though insufficient ER physician staffing still existed and open shifts were covered only when I worked excessive hours.

I was informed a senior administrator refused to approve any additional fee basis physicians until I cut the number of fee basis physicians. I was forced to fire several fee-basis (hourly wage) physicians who couldn't commit to the number of monthly shifts the senior administration was requiring. After cutting those fee basis physicians, additional approvals/hires for more fee basis physicians did not come/were not processed in a timely manner by HR. Thus I was forced to work even more hours above my scheduled workweek.

In my opinion, I believe this was a deliberate attempt by senior executive service members to make my working conditions so intolerable that I would choose to resign.

6. Because senior administrators ignored the growing problem in the Phoenix ER, short staffing and inadequate quality triage became routine within the ER in 2011 and 2012.

The quality of triage in general was extremely inconsistent depending up on the skill set of the triage nurse assigned and the number of patients presenting for triage.

At one point, I identified 3 full-time nurses who were considered extremely unreliable triage nurses by all full-time staff because of the inappropriate triaging of seriously ill patients and the frequency of mistakes made by those nurses on all shifts. However, I was told nursing staffing in the ER was too short-staffed to prevent the inexperienced and/or inadequately trained nurses from being placed in triage.

One of these nurses actually sent a seriously ill patient to the Eligibility Clinic instead of performing triage because the patient had never been registered at the Phoenix VA before.

Triaging of the patient's problem should always be done before any patient is diverted away from the ER.

New grads were allowed to do triage only after a very short period of triage training. Some of them were even trained by nursing staff who previously had demonstrated inadequate triage nursing skills.

The Phoenix ER patient flow rapidly increased and the inexperienced nurses could not keep up nor were they given sufficient time to be mentored in triage. By late 2011 and early 2012 the triage mistakes or near misses were so prevalent it was impossible for the physicians to monitor all the misses/mistakes on an hourly basis.

Although senior administrators may state that the ER usually met the minimum requirements for nursing staffing, in truth many times the "ER nurses" were float nurses from other parts of the hospital with no ER experience or specialty training. In addition,

the minimum nursing staffing was inadequate because it didn't allow an increase based on the sheer number of patients presenting for triage nor make adjustments for the high acuity of patients presenting.

Phoenix senior administration declined to institute formal nursing triage training on a recurrent basis even when the lack of nursing knowledge contributed to significant morbidity and some instances of mortality.

7. Despite my well-articulated concerns regarding the number of nursing triage mistakes and the difficulty physicians would have addressing those mistakes quickly without paper print-outs of triage notes, Phoenix senior officials ordered the cessation of all paper-based triage note print-outs.

The VA goal nationally was to move away from paper-based processing of triage notes. However, I felt this move could not be done safely at the Phoenix VA in 2011. I repeatedly explained in meetings that the majority of triage nursing notes as of 6/2011 were still inadequate with significant concerns regarding the quality of triage. Paper based print-outs allowed the physicians on duty to rapidly determine if there were serious symptoms/vital signs documented within the note that the triage nurse did not realize indicated seriously ill/potentially unstable patients. I opposed the loss of backup printed triage nurse notes because it meant the physician on duty could not quickly monitor the triage notes/vital signs/patient complaints to reassign the patient's acuity level to the proper category.

The need for close physician monitoring was quite evident based on the admission data present during that timeframe. There continued to be a high number of patients who were inappropriately designated as low-acuity (indicating non-urgent condition) in triage. These Veterans were actually high-acuity and were subsequently admitted to the hospital.

Multiple ER physicians reported to me that nursing triage quality was extremely unreliable. I repeatedly communicated those concerns to both the nursing chain of command and my physician chain of command. Senior executives still did not respond.

8. I was exposed to ongoing extremely hostile working conditions in the ER from a small percentage of nursing staff whom senior administration refused to investigate.

Beginning in approximately 2010, I became more vocal regarding the need for nurse triage training and the understaffing of triage. Shortly thereafter, a few nurses began intermittently ignoring my orders, not answering my questions in the nurses' station, not giving me verbal reports on patients, and not expediting the discharge of my patients. As a result, I asked that all ED physicians direct any concerns regarding nursing triage outcomes to me for submission in order to avoid having other physicians be the recipient of nursing backlash which could grind patient care to a halt in the ER.

By late 2011, approximately 20% of nurses were consistently ignoring my orders, failing to give me verbal report on patients, declining to notify me of ekgs, and refusing to initiate protocol orders for serious complaints like as chest pain in my patients. Patient as-

signments would be changed to my name in the computer without telling me. Those nurses were intermittently verbally aggressive toward me when I was in the ER nurses' station.

From 2011–2012, the aggressiveness towards me from those few nurses was so open that it was frequently observed by fee basis ER physicians, full-time ER physicians, other nursing staff, front desk staff, Phoenix VA police officers, and even housekeepers.

Although I communicated my concerns through the nursing chain of command, there was no significant change in the level of hostile work environment for me. I was told by the nursing chain of command that the nursing department could not stop such behavior.

When I spoke to my physician chain of command, senior administration refused to intervene on my behalf. I was told not create any problems for nursing staff which I believed included not completing formal write-ups.

9. By late February 2012, ER conditions were so dangerous that I told the on-coming medical center director, Ms. Helman, the ER should be shut down completely unless additional staffing, resources, and triage nurse training were provided.

I mentioned the multiple actual negative outcomes and potential near-misses that had been ignored by prior administrators for several years. I cited both acute and long-term short staffing shortages in the ER. I told her the last 3 days had been so dangerous for patient care that I believed the ER should be completely shut down unless there was an immediate influx of resources.

I reported conditions had been dangerous during the prior 3 days for a variety of reasons including nurses unable to write orders during shift because the current nursing protocols could not be found within the facility, extremely high flow of patient walk-ins, inadequate availability of nursing staffing, multiple instances of poor quality of nursing triage, inadequate physician staffing, and lack of ancillary services. I stated current policy for nursing order protocols was not available despite 2 months of me asking for the protocols to be located.

10. After reporting to Ms. Helman the dangerous conditions in the ED at the end of February 2012, I was subsequently told by senior administrators that the only problem in the ER was my lack of communication skills.

Within 1.5 weeks of telling Ms. Helman that the ER was grossly unsafe, I was called into a meeting with senior executives and told the only problem in the ER was my lack of communication skills.

After emphatically stating the issue was not my communication skills, I gave the group a stack of 20+ cases of actual patients with negative outcomes related to triage. I also provided additional cases for the senior executives to review after the meeting.

11. After I reported the dangerous conditions in the ER and discussing staffing shortages, no action was taken by senior executives for another 5–6+ weeks.

Despite my statements describing life-threatening situations within the ER to S. Helman at the end of February 2012 as well as my description of dangerous ER conditions at the early March

2012 meeting where I was accused of poor communication skills, no formal action or investigation was taken by the senior executives at the Phoenix VA to investigate or address the grave concerns I had verbalized.

I sent additional emails to administration emphasizing the dire conditions within the ER. In my April 2012 email to my physician chain of command I wrote " . . . I continue to be extremely concerned about the safety of our veterans who are presenting to the ED (Emergency Department) for care when the ED is saturated. Based on the events of [omitted] & [omitted] as well as numerous events over the last 24 months that have been reported on ongoing basis, I believe the potential for patient mortality in our ED is incredibly high during periods of ED saturation . . . The number of near-misses is so high during peak flow/high acuity days that multiple occurrences of significant nosocomial morbidity & mortality are inevitable . . . I have tried multiple avenues to alert this facility to the issues vital to our ED & improve provision of care in the ED despite being faced with incredibly toxic circumstances & political backbiting. This facility must not delay focusing immediate resources to reduce the risk of needless suffering and loss of life in our ED . . . "

Unfortunately, even that email would not generate any significant response for 3+ weeks from management.

Finally, in late April 2012, my chain of command agreed to meet with ER physicians to corroborate my statements. During that meeting all the ER physicians confirmed the significant care issues, staffing shortages, and nursing backlash against me.

A formal action plan was written by senior executives to address many of the issues outlined in the meeting. However, I was informed the nursing backlash against me would not be investigated. I was also told not to cause any problems for nursing staff. I was devastated to learn senior executives were ignoring nurses who had jeopardized ER patient care. I was very fearful for my patients in the ER because I knew it would be a continual struggle for me to provide quality care for ER patients in the face of continual backlash from a small group of nurses.

There should have been an immediate internal response/action plan developed after I informed former Director Helman of the severe internal crisis state existing in the ER. Inquiring into the issues including interviewing the other ER physicians should not have been delayed for almost 2 months.

12. My care for patients remained impeded by a small group of ER nursing staff throughout 2012.

The following are a few of the many episodes when my ability to care for ER patient was impeded by a small group of nurses in 2012 while I was on duty. (None of the delays were related to short-staffing issues.)

(a) Patient with an elevated heart rate of 112 was placed alone in an exam room for 2 hours and 40 minutes before I was notified. (Such a resting heart rate can indicate significant illness requiring the patient to be seen much sooner.)

(b) Nursing staff refused to draw blood on a patient because I had put a patient in a room they didn't like. (It was the only available bed and the care needed to be expedited for the patient.)

(c) A nurse did not give me report or the ekg on a patient with recent chest pain who had a history of prior heart attack.

(d) A hypertensive patient with a bad headache was put in a room for 20 minutes without ever telling me. This delayed care for a patient with a potential hypertensive emergency.

(e) On one shift, four patients were placed in rooms without giving me any type of report.

(f) An obviously ill patient with fast heartbeat was placed in a room without giving me any type of report on the patient.

(g) A nurse refused my request to respond to telemetry alarm monitors on my patient even though the nurse was assigned to the room and was not otherwise occupied.

(h) Labs I had ordered on an ill patient were still not drawn 3 hours after I ordered them.

(i) My chest x-ray order for a patient with shortness of breath was ignored for 3 hours despite my asking the nurse twice to have it completed.

(j) A stat ekg I ordered on a patient was not done for 2.5+ hours and my other orders were delayed including orthostatic vital signs.

(k) IV fluid administration was significantly delayed because a nurse didn't want to restart a heplock on my patient.

(l) Care was delayed when the pregnancy test and other tests I ordered were not done.

I continued to communicate my concerns to the physician and nursing chains of command without any success.

13. In December 2012, I was notified unexpectedly that I was being laterally transferred out of the ER to the Post-Deployment Clinic because of a "critical need" which management would not specify.

I was told this administratively-driven lateral transfer was necessary to meet a critical need in the Post-Deployment Clinic. However, that clinic had been a defunct medical clinic for 1.5 years prior to my transfer. It only contained a social work program working with returning combat Vets and a part-time polytrauma case manager. There was one physician assistant who performed basic registry exams for traumatic brain injury. These types of exams do not require a physician to complete.

My chain of command declined to specify the critical need in the Post-Deployment clinic that I was supposed to address. It took over a month for senior administrators to grant me clinical privileges to see any Veterans.

My transfer to the Post-Deployment Clinic left the ER critically short-staffed. At management's request, I returned for a few shifts over the Christmas holiday to provide emergency coverage for open shifts.

Despite the circumstances of the transfer to the Post-Deployment Clinic, I eventually discovered a way to make my position an important adjunct to the OEF/OIF/OND Transition Services social work team.

14. I chose to submit a confidential OIG report to address multiple health and safety concerns within the Phoenix VA that were being ignored by administration.

In 2013, I was working on a project to reduce the risk of suicides among Veterans. Despite phenomenal attempts by the Suicide Prevention Team to work within the confines of grossly inadequate resources, the rates of suicide at the Phoenix VA increased over a very short time span. I inadvertently became aware of long-standing Phoenix VA system inadequacies that were placing our Veterans at higher risk of successful suicide completion. Senior administration's lack of response heightened my concerns.

I decided to initiate an OIG complaint and submit it through my senator's office. Our nation, has lost too many Veterans from all eras to suicide. While no one factor will prevent a suicide, as health care providers we are obligated to make the safety net as tight as possible in our attempt to do outreach to those who are considering taking their own lives.

When I chose to initiate the OIG complaint, I was aware of previous inadequate OIG investigations at the Phoenix VAMC and failures to maintain confidentiality of those making the complaint. I could not submit the complaint anonymously because that would have severely limited the scope of the pending OIG investigation.

I organized my complaint so it would address as many patient care and safety issues as possible. I hoped this would increase the likelihood that my OIG complaint would result in significant positive changes within the Phoenix VA.

I went to my fellow Phoenix VA employees with whom I had developed a trusted relationship and asked them to provide me with information regarding the most serious issues within the VA facility. The problems must be easily proven and be urgent enough that the issues could not wait for resolution by the normally ponderous VA process of change. It was equally important the information could not be traced back by management to my "sources". I wanted only me to be the only target if my name was not kept confidential by the OIG. The Phoenix VA couldn't afford to lose any more good employees if management chose to retaliate against anyone else whose name might be associated with the report.

As the result of the information collected as well as my firsthand knowledge of facility issues and overt backlash, I wrote a lengthy complaint detailing the various problems. When I presented my written OIG complaint to staff at Senator McCain's office, the seriousness of the VA situation was evident to even those staff who had no health care background. I was informed the most serious safety issues listed in my complaint would be forwarded with a request for an expedited investigation performed by an outside OIG team to address the issues and maintain the confidentiality of my name.

Some of the issues in my complaint included disturbing system issues involving suicides, statistical manipulation of the wait list, failure to prioritize appointments according to national VA policy, and improper distribution of complex patients.

15. My confidential 2013 OIG complaint regarding multiple safety concerns within the facility resulted in overt retaliation against me.

My plan to address system deficiencies failed almost completely. My name was not kept confidential by the OIG. Shortly after the national VA acknowledged receipt of my complaint, I was placed on administrative leave for about a month and investigated for alleged wrong-doing for including truncated patient information in the confidential OIG complaint submitted through approved channels.

I was told I acted outside the scope of my duties as Post-Deployment medical director and "may have" violated privacy policy by including patient information to support my allegations regarding the disturbing suicide trends at the facility.

I eventually would receive a written counseling in January 2014 for violating privacy policy and for working outside the scope of my duties as purportedly evidenced by the content of the OIG complaint submitted for me by Senator McCain's office. There was no information in the written counseling specifying exactly what policy I had violated or how it was concluded I was working outside the scope of my duties. I was not given access to the investigative file. Instead, I was told the investigative file had been "shredded for my protection".

I sent a formal request outlining my concerns and requesting to have the investigative file re-created. I also asked to be informed of which patient privacy policy I violated. I subsequently was told that HR determined it did not need to respond because written counseling did not rise to the level of disciplinary action that Title 38 employees were allowed to challenge.

My senior physician chain of command did not intervene on my behalf, and thus clearly supported HR's decision. The written counseling was never rescinded even though HR declined to tell me the name of the policy I supposedly violated.

16. The 2013 OIG report of my complaint was never officially provided to me and can't be found on the OIG web site. I was forwarded a brief email received by the senator's office indicating the investigative findings were benign. Of note, the investigation found no significant problems with scheduling issues.

I have never seen the official OIG report on my 2013 complaint and do not know if one exists. Senator McCain's office made attempts to locate the report for me without success. There is no indication of the investigation on an OIG Web site search.

I subsequently learned the OIG has complete discretion as to which reports it puts on its Web site. I was told anecdotally the VA OIG often doesn't list any reports which are critical to senior administrators. Recently I was sent an OIG report critical to senior administrators at another VA. That report issued in 2014 and was assigned an OIG case number. However, this report cannot be located on the OIG Web site and was obtained only by FOIA request.

SECTION IV:

VA Horizontal Violence: Specific Retaliation Tactics Against Title 38 Health Care Providers (Physicians, Surgeons, Dentists)

Note: Variations of some tactics are commonly used against wage grade employees & Title 38-hybrid employees. The implications may differ (depending on the skill set) but the outcomes are similar.

Overview Summary

A. Types of Retaliation:

1. Sham peer review.
2. Malicious down-grading of proficiencies.
3. Deliberate understaffing of Title 38 provider positions.
4. Deliberate understaffing of necessary ancillary personnel.
5. Inequitable distribution of extremely challenging patients to overburden provider.
6. Faulty clinical profile to overwhelm provider.
7. Unjustified written counseling.
8. Lateral transfer for factitious reasons.
9. Exploitation of "24/7" work contract.
10. False accusations of patient privacy violations in retaliation for whistle-blowing.
11. Unreasonable timeframe assigned for completion of non-essential training requirements or extraneous tasks.
12. Removal of teaching privileges to ostracize provider.

B. Clinical Implications (in numerical order based on retaliation type):

1. Veterans are denied the skills of talented, qualified providers who are fired due to unjustified accusations of poor medical skills.
2. Qualified candidates for direct patient care positions or supervising administrative positions are not promoted to positions where they can use their skills sets to fulfill the VA's mission for quality health care.
3. Provision of direct patient care services is greatly slowed.
4. Direct patient care time is diminished due to additional, excessive daily tasks.
5. Punitive and dangerous system is used for managing care of complex Veterans.
6. Delays occur in necessary follow-up required for labs, studies, and consults.
7. Ineffective disciplinary system doesn't support high quality care for Veterans.
8. Potentially dangerous health and safety problems perpetuate when advocates for quality care are removed from clinical settings.
9. The risk of patient care mistakes increases when providers are physically/mentally exhausted.
10. Malicious administrative conduct stifles the reporting of future legitimate patient care concerns and perpetuates unsafe situations.
11. Delays occur in completion of important administrative tasks related to patient care.
12. Increased potential for patient health care mistakes occur when there is loss of talented attending physicians who normally would guide students/new doctors to consistently deliver high quality medical care.

C. Professional Implications (aggregate):

In an unethical and unprofessional institutional culture, providers quickly develop high stress, low morale, and physical/mental exhaustion. Providers who advocate for patient care and safety against the local administration's status quo are isolated in their work environments, demoralized, and professionally impeded in

their careers. In some cases, providers are exposed to extreme retaliation that can effectively ruin their medical careers in both the VA system and the private sector.

D. Outcomes (aggregate):

1. Administrators have extremely effective methods to ensure compliance with their personal agendas which are disconnected from the mission and stated values of the Department of Veterans Affairs.
2. The VA system is unable to effectively retain and/or recruit well-qualified providers who have been/would be effective advocates for patient health and safety.
3. Veterans are denied the highest quality, efficient medical services within the VA despite VA administration having access to a talented pool of dedicated patient care providers already employed within the system.
4. The U.S. government loses money compensating for high staff turn-over and defending administrators' inappropriate personnel decisions.
5. The horizontal violence within the VA institutional culture propagates.
6. Outcomes 1 through 5 above threaten the viability of the VA and undermine its ability to meet and exceed our obligations to the nation's current and future Veterans.

Detailed Explanation of Retaliation Tactics Against Title 38 Employees

1. Sham peer review.

Note: In contrast to a sham peer review, a professional peer review is a formal, lengthy review done of a physician's cases by his/her peers and is initiated only when there is legitimate concern the physician may not be following medical standards of care. The outcomes are based on objective findings, not subjective opinion.

Tactic: A well-orchestrated attempt to sabotage a physician's credibility/professional reputation via organizing a sham review of cases by the administrator's associates/cronies. Even though there is no objective evidence of improper care, the predetermined written "findings" imply the physician has, at a minimum, subjective deficiencies in professional or personnel qualities. (The practice of sham peer review is not considered a prohibited personnel practice. The Office of Special Counsel doesn't accept sham peer review cases.)

Clinical implications: Veterans are denied the skills of talented, well-qualified physicians when those providers are relieved of patient care duties or fired due to unjustified accusations of poor medical skills.

Professional implications: Professionally and personally devastating to the provider. The physician has to fight the sham findings at great financial expense in civil court or via the Merit Protections Board. For the rest of his/her professional career, the physician has to report on job applications and license renewals that he or she was the subject of a peer review.

Outcome:

a. Management can effectively and permanently sabotage a physician's ability to be gainfully employed anywhere as a physician inside or outside of the VA system.

b. Threat of a sham peer review can effectively stifle physicians who want to voice serious concerns about patient safety.

c. Fighting a sham peer review can financially devastate a physician who is pitted against the unlimited legal resources of the U.S. Department of Veterans Affairs.

d. Patient care is delayed as yet another VA physician chooses to resign or retire instead of facing a sham peer review.

2. Maliciously down-grading proficiencies.

Tactic: Deliberately reducing the accuracy of a provider's yearly written performance evaluation on the whim of the administrator instead of completing the evaluation based on objective criteria normally used to judge accomplishments of providers.

Clinical implications: Qualified candidates for direct patient care positions or supervising administrative positions are not promoted to positions where they can use their skills sets to fulfill the VA's mission for quality health care.

Professional implications: Physicians and other providers are not allowed to expand their professional careers. If the provider decides to obtain a position at another VA or in an outside institution, the unfairly downgraded proficiencies make the provider less apt to be selected for the new position.

Outcomes:

a. Patients are denied the benefits of having the most qualified personnel in supervisory/other positions who would normally work toward efficient/high quality care.

b. Management has a direct/efficient method of sabotaging the professional reputation of a provider who verbalizes concerns about patient safety, fiscal irresponsibility, or prohibited personnel practices.

c. Management saves money on bonuses associated with providers who earn "outstanding" ratings on yearly proficiencies.

d. Management wields significant power to create compliance with administrative edicts by granting monetary awards to providers based on whim instead of merit.

e. Rank and file staff member burn-out.

f. Impedance of a provider's ability to be employed in the private sector or at another VA.

3. Deliberate understaffing of provider/Title 38 provider positions.

Tactic: Vacancies or identified needs for staffing increases are ignored by administrators so that remaining Title 38 employees have to manage ever-increasing patient loads.

Clinical Implications: Provision of direct patient care services is greatly slowed. Providers are routinely managing complex patient loads that are 10%–50% above the VA's predetermined safe levels for provider patient panels. The risk of overlooking key pa-

tient needs is very high. There is often slowed clinical response to mountains of patient requests flooding provider's clinic.

Professional Implications: Providers frequently worry about meeting the complex needs of huge patient panels that outstrip the available resources. Providers are also penalized on their yearly performance appraisals because they can't keep up with the unwieldy patient flow.

Note: Unlike wage-grade, non-supervisory positions, Title 38 employees can be penalized on performance appraisals even if deficiencies in care are directly related to chronic understaffing/excessive patient workloads.

Outcomes:

a. Patient appointments/consults are difficult to schedule because the provider is booked so far into the future.

b. Delays in patient care and interpretation/communication of testing results/future needs.

c. Senior administrators save money/reap potential bonuses for avoiding salary expenditures.

d. Rank and file staff members burn-out as workweeks extend far beyond 50–60 hours and their yearly proficiencies drop despite every attempt by the provider to meet the needs of the vast patient load.

4. Deliberate understaffing/failing to post positions for necessary ancillary personnel.

Tactic: Vacancies or identified staffing needs are unanswered by managers so that basic clerical/ancillary functions of clinic are not addressed.

Clinical implications: Direct patient care time is diminished due to additional, excessive daily tasks. Providers have to absorb those tasks in order to keep the clinic running. This pulls providers away from direct patient care time.

Professional implications: Providers have their administrative & clinical time stretched so incredibly thin that they are often unable to fully meet the needs of their patients during any given day. Providers have to use off-duty time to meet their ethical and medical obligations to patients. They are also faulted for failing to meet clinical requirements or performance measurements in a timely fashion.

Outcomes:

a. Provision of direct patient care is slowed.

b. Patient frustration because they don't understand why phones aren't answered, lab results aren't timely communicated, and messages aren't returned promptly.

c. Management can reap bonuses for keeping labor costs low by avoiding the salary expenditures for hiring/replacing basic staff members.

d. Management is able to wring more time out of salaried rank and file employees.

e. Rank and file staff member burn-out as workweeks extend far beyond 50 hours and impossible standards of achievement are mandated.

5. Inequitable distribution of extremely complex patients to overburden provider.

Tactic: Extremely complex patients are "dumped" onto a provider's panel en masse without allowing the provider additional clinical time to address the patient needs at each visit. These patients are time-consuming in terms of physical/clinical interactions needed to address multiple physical problems and approach the psychological issues inherent to the patient's ability to engage in the health care process.

Clinical implications: Punitive and dangerous system used for managing care of complex Veterans. The provider is chronically "running behind" in clinic trying to meet the pertinent needs of each Veteran within an appointment timeframe that is too short for such a complex patient.

Professional implications: Although the provider tries to give quality patient care to each Veteran, the provider is penalized on proficiencies and in meetings for "taking too long" with his/her patients despite the complexity of the patients. The provider is rated negatively by administrators because the provider cannot process the complex panel of patients as fast as fellow providers who have lighter/less complex patient panels.

Outcomes:

a. Management easily creates burdensome working conditions to harass staff member.

b. Managers who have patient panels quickly can reduce their own work load/improve their own efficiency ratings by dumping complex patients onto other provider panels.

c. Patient frustration because his/her assigned provider is chronically late starting appointments or only has time to deal with 1–2 active problems during the appointment.

d. A greater number of patients can be neglected when provider time is routinely monopolized by fewer but much more complex patients.

e. Rank and file staff member burn-out.

6. Faulty clinical profile to overwhelm provider.

Tactic: Providers are given inadequate administrative time to follow-up on electronic alerts and other administrative tasks. The clinic appointment time is reduced to a bare minimum in order to give the appearance of adequate provider staffing in the entire clinic.

Note: Electronic alerts are computer notifications of various information of which the provider must be aware. Examples of electronic alerts include requests to co-sign chart notes or the receipt of results from labs, radiology studies, consults, or pharmacy actions. Although some alerts can be cleared in seconds, other alerts can take from 5–15 minutes each because follow-up action is required. At the Phoenix VA, primary care providers average 85 electronic alerts per day.

Clinical implications: Delays occur in necessary follow-up required for labs, studies, and consults because providers are inundated with administrative tasks.

Professional implications: Providers feel chronically overwhelmed and stressed. His or her yearly proficiency is downgraded because the provider is unfairly labeled as being "inefficient" even though the provider has been assigned tasks that no human being reasonably could meet within a 40–50 hour workweek.

Outcomes:

a. Management is able to wring more time out of salaried employees.

b. Management can save money on proficiency bonuses for staff by reducing the number of providers labeled as "outstanding" on yearly proficiencies.

c. Rank and file staff members burn-out as workweeks extend far beyond 50–60 hours.

7. Unjustified written counseling.

Tactic: Written counseling is used only as a punitive stepping stone for unjustified disciplinary actions and as false justification for penalizing employee proficiencies.

Clinical implications: Ineffective disciplinary system is created which doesn't ensure high quality care for Veterans. Providers who perform appropriately are penalized unjustly. Providers who demonstrate inappropriate behaviors are not issued written counseling as long as those providers are pleasing the administrative chain of command.

Professional implications: Providers are helpless to defend themselves because written counseling doesn't rise to the level of disciplinary action that Title 38 employees are allowed to challenge.

Outcomes:

a. Administrators have an easy tool to discipline providers without being challenged.

b. Written counseling is never used to correct inappropriate behaviors of providers who are favored by administrators.

c. Rank and file staff member burn-out.

8. Lateral transfer for factitious reasons.

Note: Lateral transfers are allowed in only 3 situations: an employee requests the change and a vacancy is open in the new workstation; an employee faces a disciplinary action and management believes a new workstation would be a better fit for the employee's skill set; or there is a true "critical need" in another area which management must meet by transferring the employee to the new location even if the employee doesn't desire the transfer. Declining a "critical need" lateral transfer can result in disciplinary action against the employee.

Tactic: An employee is laterally transferred to a less favorable work site based on a factitious "critical need" in the new area. Often the employee will then be penalized on his/her proficiencies for not performing well in the new area.

Clinical implications: Potentially dangerous health and safety problems perpetuate when advocates for quality care are removed from clinical settings.

Professional implications: Providers become hesitant to verbalize concerns for patient health and safety in any work station.

Outcomes:

a. Management has a powerful tool to punish employees who persistently advocate for patient care/other issues against administration's party line.

b. Effective, dedicated professionals are essentially "moth-balled" to areas where they have less of an ability to effect positive change within the work-environment.

9. Exploitation of "24/7" work contract.

Note: A full-time federal Title 38 employee at one agency cannot work for another federal agency simultaneously even if the second agency's work hours fall within the federal employee's off-duty work hours from the first agency. In my limited understanding, I believe that the salaried Title 38 employee contract has been interpreted in recent years to mean the employee can only be scheduled for 80 hours per 2 week pay period even if the actual work day extends far longer. When a Title 38 employee's workday inadvertently lasts more than the usual timeframe, the employee does not get paid overtime or comp time. A VA Title 38 employee may be scheduled to work more than 80 hours per 2 week pay period if the VA facility director declares an emergency at the VA facility. The true interpretation/implication of the 24/7 work contract needs to be officially clarified in writing by senior VA officials.

Tactic: Clinics are set up with faulty administrative time/odd hours that routinely extend the usual 8 hour/day (40 hours/workweek) to 10–12 hours per day (50–70 hours/workweek).

Clinical implications: The risk of patient care mistakes increases when providers are physically/mentally exhausted during any given workweek.

Professional implications: Even if actual mistakes are not made, providers are physically/mentally exhausted and greatly fear making a critical mistake or overlooking important health care needs of their patients.

Outcomes:

a. Management is able to wring more time out of salaried employees.

b. Providers are quickly burn-out as their personal/family time is steadily eroded.

10. False accusations of patient privacy violations in retaliation for whistle-blowing.

Tactic: Even though the employee uses the approved administrative channels of VA oversight, any provider who includes the necessary patient care information to support the allegations of wrong-doing is subsequently disciplined for violating patient privacy. In extreme cases of administrator wrath, the practitioner will be reported to his/her credentialing board for privacy violations.

Note: Disclosure of pertinent patient care information in support of whistle-bower activity through approved channels of VA oversight is not a patient privacy violation. Unfortunately, the Office of

Inspector General has declined thus far to put that opinion in writing. With lengthy legal efforts, these inaccurate disciplinary actions can be overturned, but the process may take years.

Clinical implications: Malicious administrative conduct stifles the reporting of future legitimate patient care concerns and perpetuates unsafe clinical situations. Patient care cannot rise to the high level of quality care needed by our Veterans until health and safety issues are reported and corrected.

Professional implications: Fear of retaliation can silence providers or reduce their ability to effectively advocate for patients.

Outcomes:

a. Administrators have a powerful tool to suppress any information that may be contrary to a positive public image of the VA facility.

b. The quality of patient care in the VA can never reach its full potential.

c. The U.S. taxpayers foot the bill for legal wrangling between the VA who supports the disciplinary action and the Office of Special Counsel which is trying to overturn the disciplinary action.

11. Assigning unreasonable timeframes for completion of excessive training requirements/tasks to penalize the provider.

Tactic: Mandatory training requirements/task assignments, often assigned at the last minute, are required to be done within a short timeframe without allowing any flexibility in administrative time. If requirements/tasks are not completed, the provider is penalized on proficiencies or in write-ups.

Clinical implications: Delays occur in the completion of important administrative tasks related to patient care. Administrative time for most providers is filled with daily tasks including reviewing mandatory electronic alerts. Being given additional tasks without additional time allowance means the providers may have to ignore administrative tasks related to patient care during allotted timeframes to complete the extraneous or nonessential tasks. This tactic erodes the Title 38 employee's ability to complete other/more pressing administrative tasks within the course of daily duties.

Professional implications: Staff frustration/burn-out because unreasonable time demands force the employees to use lunch breaks, weekends, or other off-duty hours to either complete training criteria/extra duties or follow-up on patient care administrative duties.

Outcomes:

a. Management is able to wring more time out of salaried employees.

b. Rank and file staff member burn-out as workweeks extend far beyond 50–60 hours.

12. Removal of teaching privileges to ostracize provider.

Tactic: An administrator will exclude the physician from teaching privileges, an inherently renewing professional activity.

Clinical implications: Increased potential for patient health care mistakes occur when there is loss of talented attending physicians who normally would guide students/new doctors to consistently deliver high quality medical care.

Professional implications: Involuntary removal of teaching privileges isolates/ostracizes the professional provider within the workplace.

Outcomes:

a. Management is able to effectively isolate "trouble-makers" within the work environment who threaten administrator's status quo.

b. Quality of training in the facility is reduced by the loss of an effective educator.

SECTION V VA Horizontal Violence: General Retaliation Tactics Against all VA Employees

Overview Summary

A. Types of Retaliation:

1. Open ridicule in meetings.
2. Anonymous "report of contact" writing campaigns to sabotage employee's credibility and justify malicious disciplinary actions.
3. Deliberate exclusion of employee from participation in projects necessary for promotion/career advancement.
4. Failure to promote on merit by willfully denying promotions to the best qualified candidate.
5. Reassignment/relocation in the workplace in order to debase an employee.
6. Abrupt firing of probationary employees who report patient care concerns, identify misuse of facility resources, and/or question violations of human resource policy.

B. Clinical Implications (in numerical order based on retaliation type):

1. Legitimate hazards to patient care and safety remain unaddressed due to perpetuation of hostile work environment.
2. The firing, resignation, or failure to promote competent and dedicated employees impairs the quality of direct and/or indirect Veteran services.
3. The available staffing expertise is not utilized for the maximum benefit of the patients.
4. Because less qualified employees do not possess the mandatory traits/skills required for their new positions, the quality of all direct and/or indirect care is compromised.
5. An employee who feels debased often cannot perform new duties to meet the standards and requirements of the VA system.
6. Potential health and safety concerns are not addressed appropriately.

C. Staff Implications (aggregate):

In a system where there is disparate advancement opportunities, unequal balance of power, and emphasis on retaliation, qualified employees dedicated to the care of Veterans and the VA mission

are subjected to horizontal violence that prevents them from achieving their full career potential and encourages them to seek career opportunities elsewhere. Less qualified employees are allowed to fill direct and indirect care positions which results in a lower standard of care throughout the VA system.

D. Outcomes (aggregate):

1. Administrators can employ a variety of retaliatory methods to debase employees and to suppress identification of system deficiencies that may make the administration look unfavorable.
2. The system is unable to effectively retain and/or recruit employees who have been/would be effective advocates of health and safety in all aspects of the VA health care system.
3. Veterans are denied high quality, efficient medical services within the VA despite administration having access to a talented pool of dedicated employees already working within the system.
4. The U.S. Government spends inordinate amounts of money trying to legally defend administrators' retaliation against employees and also compensate for high staff turn-over.
5. The horizontal violence within the VA institutional culture propagates.
6. Outcomes 1 through 5 above threaten the viability of the VA and undermine its ability to meet and exceed our obligations to the nation's current and future Veterans.

Detailed Explanation of Retaliation Tactics Against all VA Employees

1. Open ridicule in meetings.

Tactic: In meetings and other personal interactions that don't leave a paper trail, administrators use verbal behavior such as raising voice, profanity, sarcasm, and interruption in response to an employee verbalizing concerns about safety or care. Nonverbal behaviors such as crossing arms, rolling eyes, and scowling are done while the employee is speaking about his/her concerns.

Clinical implications: Legitimate hazards to patient care and safety remain unaddressed due to perpetuation of hostile work environment.

Staff implications: The employee immediately becomes aware he/she is displeasing administrators and is often humiliated in front of co-workers. Thereafter, employees remain silent to avoid becoming targets for administrative abuse.

Outcomes:

a. Management has a method of discouraging employees from voicing concerns about safety.
b. Management can later claim "no knowledge" of the problem if the deficiency/issue later comes to the surface in another manner.
c. Lines of facility communication are impaired because rank-and-file staff avoid meetings.

2. Anonymous "report of contact" writing campaigns to sabotage employee's credibility and justify malicious disciplinary actions.

Tactic: Administrators orchestrate a "write-up" campaign against an employee wherein the employee is the subject of fal-

sified or exaggerated reports of contact from employee's co-workers. The employee is never told who composed each "report of contact" write-up. The employee is then penalized/disciplined within the workplace based on these write-ups against which the employee cannot easily mount a defense.

In a variation of this tactic, an administrator will pressure co-workers into writing up reports of contact on incidents, even if those incidents are outdated and/or insignificant. The co-workers are forced to write up the employee or face retaliation themselves from the administrator. Co-workers who refuse are viewed as "not being team players" or are told they are "unprofessional". These derogatory labels will negatively affect future proficiencies for the co-workers.

Clinical implications: The firing, resignation, or failure to promote competent and dedicated employees impairs the quality of direct and/or indirect Veteran services.

Staff implications: An employee feels attacked by unseen enemies or by his/her own co-workers.

Outcomes:

a. Administrators have a tool to easily justify disciplining employees on trumped-up charges or minor infractions.

b. Administrators have a divisive tool to isolate an employee or break up a cohesive team of employees.

c. Employees have significant distrust of each other.

3. Deliberate exclusion of employee from participation in projects necessary for promotion/career advancement.

Tactic: Administrators avoid assigning an otherwise qualified employee to participate in projects that are needed to advance the employee's VA career. This is done because the administrators view the employee as a threat to the current status quo.

Clinical implications: The VA doesn't utilize its staffing expertise to the maximum benefit of its operational goals.

Staff implications: An employee's potential remains undeveloped even though the employee otherwise is truly capable of expanding his/her role within the VA.

Outcomes:

a. Administrators have an easy way to prevent employees who are vocal on patient care issues from ever being given opportunities to achieve career fulfillment or advance into supervisory roles.

b. Inappropriate utilization of staffing resources.

c. Overall staff productivity is decreased.

4. Failure to promote on merit by willfully denying promotions to the best qualified candidate.

Tactic: Administrators deliberately overlook qualified candidates in favor of the administrators' friends/co-workers who conform to the unethical administrative power structure.

Clinical implications: Because less qualified employees do not possess the mandatory traits/skills required for their new positions, the quality of all direct and/or indirect care is compromised.

Staff implications: Employees with desired expertise are extremely frustrated because they are unable to apply those skills to the maximum extent possible within their own department. Positions are filled with candidates who do not possess the preferred expertise and qualifications for the job.

Outcomes:

a. An administrator has now filled positions of responsibility with unqualified individuals who continue to promote an unethical and unsafe work environment.

b. Government monies are wasted on avoidable legal proceedings between the VA that supports the administrator and the Office of Special Counsel/EEOC which is trying to overturn the prohibited personnel action.

5. Reassignment/relocation in the workplace in order to debase employee.

Tactic: An experienced employee is transferred to an entry level position/other position that doesn't effectively use employee's skill set while the employee is being "investigated" for an alleged infraction.

Clinical implications: An employee who feels debased often cannot perform new duties to the standards and requirements of the VA system.

Staff implications: An employee's dignity is reduced when removed from a role that he/she had great personal pride in fulfilling.

Outcomes:

a. Administrators have an effective tool to isolate an employee or break-up a cohesive group of workers who verbalize health/safety concerns.

b. Inappropriate use of experienced staff member.

c. Loss of productivity.

6. Abrupt firing of probationary employees who report patient care concerns, identify misuse of facility resources, and/or question violations of human resource policy.

Note: Administrators have the ability to fire any probationary employee without cause during a period of probation that can last up to 2 years. This ability is supposed to be judiciously applied only in situations where the employee is not a good fit for the VA.

Tactic: As a way of filtering out new employees who express health/safety concerns or violations of other policies/procedures, an administrator unjustly/abruptly terminates these probationary employees simply because they are viewed as a threat to the administrator's power base.

Clinical implications: Potential health and safety concerns are not addressed appropriately within the work environment.

Staff implications: Probationary employees are afraid to vocalize health and safety concerns because they fear unjustified job loss.

Outcomes:

a. Administrators have an effective leverage over probationary employees to suppress any identification of system deficiencies that may make the administration look unfavorable.

b. In order to meet administrators' personal goals, there can be coercion of probationary employees to do activities that are not in keeping with VA official standards of conduct.

PREPARED STATEMENT OF MR. DAVIS

Good evening, I'm Scott Davis, a Program Specialist at the Health Eligibility Center in Atlanta, Georgia. I filed for whistleblower protection in January 2014.

I'd like to thank Chairman Miller, Ranking Member Michaud and the committee for their leadership and for providing a platform, so the voices of VA Whistleblowers can be heard.

I urge the committee to take prompt action as time is running out. Every day a window of opportunity is closing on a Veteran to receive care before irreparable harm is done to their health or mental well-being. Because of the inaction of senior VA officials, some Veterans even face the burden of being billed for care their service has earned.

As noted in the Office of Special Counsel's June 23rd report, VA leadership has repeatedly failed to respond to concerns raised by whistleblowers about patient care at VA. Despite the best efforts of truly committed employees at HEC and the Veteran Health Administration, who have risked their careers to stand up for Veterans, management at all levels ignored or retaliated against them for exposing the truth.

CRITICAL ISSUES REPORTED TO SENIOR VA OFFICIALS BY WHISTLEBLOWERS AT THE HEC INCLUDE:

1. Mismanaging critical Veteran health programs and wasting millions of dollars on an Affordable Care Act direct mail marketing campaign.
2. The possible purging & deletion of over 10,000 Veteran health records at the Health Eligibility Center.
3. A backlog of 600,000 pending benefit enrollment applications.
4. Nearly 40,000 unprocessed applications discovered in January 2013. These were primarily applications from returning service members from Iraq and Afghanistan.

THE HARASSMENT I EXPERIENCED AT THE HEC WAS FROM TOP LEVELS OF MANAGEMENT:

1. My whistleblower complaint to White House Deputy Chief of Staff Rob Nabors was leaked to my manager Sherry Williams, who stated in writing, that she was contacting me on behalf of Acting Secretary Gibson and Mr. Rob Nabors. Neither Mr. Gibson, nor Mr. Nabors have responded to that fact.
2. My employment records were illegally altered by CBO WFM, Director Joyce Deters.

3. I was illegally placed on a permanent work detail by Assistant Deputy Under Secretary, Philip Matkovsky and Acting Chief Business Officer, Stephanie Mardon.

4. I was placed on involuntary administrative leave, curiously at the same time the OIG's investigation was occurring in Atlanta by Acting HEC Director Greg Becker.

UNFORTUNATELY MY EXPERIENCE IS NOT UNIQUE.

Daron and Eileen Owens, who work at the VA Hospital in Atlanta, GA, have experienced the same retaliation for reporting medical errors and patient neglect as well as misconduct by senior VA police officials.

Our Local 518 Union President, Daphne Ivery is routinely harassed as a direct consequence of assisting me and other disabled employees with addressing retaliatory actions by members of management. Mr. and Mrs. Owens as well as Ms. Ivery are Veterans. In fact over 50% of the 300 employees at our office are disabled Veterans.

In 2010 allegations surfaced that applications for VA health care were being shredded at the HEC. Under the direction of the HEC Director and Deputy Director, Ms. Kimberly Hughes, Former Associate Director for Informatics and her team began to investigate this allegation. Her team discovered nearly 2,000 applications that were reported as being processed in WRAP that did not appear as new enrollees in the Enrollment System.

Ms. Hughes, investigation was abruptly closed by the HEC Director's Office. Although she completed a report of her findings it is unclear whether that report was given to the OIG or whether the nearly 2,000 Veterans who sought medical care from VA ever received the health care they earned. She was also subjected to harassment and intimidation, because she dared to advocate for Veterans!

RELEVANCE TO THE COMMITTEE JUSTIFIES CLOSER REVIEW

The whistleblower statements I have provided to the committee were also provided to the OIG and are more relevant to this committee than many may realize. I urge additional review of those whistleblower statements.

In addition to providing specific examples of whistleblower harassment to the committee, I hope my testimony provides some insight on three key issues VA management fails to address:

1. Reckless waste of federal funds and causing greater backlog of enrollment applications for the sole purpose of achieving performance goals.

2. Why there is resistance to implementing proper and effective processing and reporting systems and the source of that resistance, as addressed by Dr. Draper during her testimony.

3. The need to remove ineffective managers and the urgent need for the VA Management Accountability Act to be fully implemented, as stated by Mr. Griffin.

WHY IT IS SO CRITICAL TO ACT QUICKLY:

More records and documents could be deleted or manipulated to mask backlog and mismanagement, due to system integrity issues.

VHA is losing talented, committed individuals who continue to transfer to other agencies or are harassed to the point of resignation. The volume of EEO complaints should be examined.

TV commercials are currently airing across the country about VA career opportunities. VA will not attract much needed health care professional to improve the quality of care, if it is known and even stated by current employees that "VA is not a place you want to work!"

Most importantly: transitioning management, clearing backlog, restructuring care, implementing new access programs and building a quality organization will require the intervention and strong oversight by Congress.

Thank you again for this opportunity. I welcome your questions on the issues I've noted or any items I've submitted to the committee.

PREPARED STATEMENT OF CAROLYN LERNER AND ERIC BACHMAN

"VA Whistleblowers: Exposing Inadequate Service Provided to Veterans and Ensuring Appropriate Accountability"

July 8, 2014, 7:30 P.M.

Chairman Miller, Ranking Member Michaud, and Members of the Committee:

Thank you for the opportunity to testify today about the U.S. Office of Special Counsel (OSC) and our ongoing work with whistleblowers at the Department of Veterans' Affairs (VA). I am joined today by Deputy Special Counsel Eric Bachman, who is supervising OSC's efforts to protect VA employees from retaliation.

I. The Office of Special Counsel

OSC is an independent investigative and prosecutorial federal agency that protects the merit system for over 2.1 million federal employees. We fulfill this good government role with a staff of approximately 120 employees - and the smallest budget of any federal law enforcement agency. Our specific mission areas include enforcement of the Hatch Act, which keeps the federal workplace free of improper partisan politics. OSC also protects the civilian employment rights for returning service members under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Over the last three years, OSC has successfully implemented the USERRA demonstration project this Committee established as part of the Veterans Benefits Act of 2010. With limited resources, we have found innovative ways to resolve USERRA claims and ensure that service members are positioned to succeed upon their return to the civilian federal workforce.

In addition to enforcing the Hatch Act and USERRA, OSC is also uniquely positioned in the federal government to receive whistleblower disclosures and protect whistleblowers from retaliation. We do this in two distinct ways.

First, we provide a safe channel for federal employees to disclose allegations of waste, fraud, abuse, illegality, and/or threats to public health and safety. We receive approximately 1,200 whistleblower disclosures annually. If the disclosure meets the high threshold required for triggering a government investigation, we then refer it to the agency involved. After an OSC referral, the agency is required to investigate and submit a written report to OSC. OSC analyzes the agency's report, receives comments from the whistleblower, and transmits our findings and recommendations to the President and Congress. OSC's work with whistleblowers often identifies trends or areas of concern that require greater scrutiny and/or systemic corrective action. Our testimony today will provide additional detail on OSC's June 23, 2014 letter to the President and Congress, which made recommendations in response to dozens of whistleblower disclosures from VA employees across the country.

Second, OSC protects federal workers from "prohibited personnel practices," especially retaliation for whistleblowing. OSC receives approximately 3,000 prohibited personnel practice complaints annually, a number that has increased 51% over the last five years. Most of these complaints allege retaliation for whistleblowing or protected activity, such as cooperating with an OSC or Inspector General investigation. In these cases, OSC conducts the investigation and determines if retaliation or another prohibited personnel practice has occurred. After an investigation, OSC has the ability to secure relief on behalf of the employee and to seek disciplinary action against any employee who has engaged in retaliation. Our testimony today will provide the Committee with a summary of OSC's efforts to protect VA employees from retaliation.

Finally, we will discuss a number of encouraging commitments made recently by the VA, in response to our June 23 letter. If implemented, these commitments will go a long way toward ensuring that whistleblowers feel free to step forward, and that their information will be used to improve the quality of care within the VA system.

II. Whistleblower Disclosures

As stated in our June 23, 2014 letter to the President, which is attached to this testimony, "The goal of any effective whistleblower system is to encourage disclosures, identify and examine problem areas, and find effective solutions to correct and prevent identified problems from recurring." Unfortunately, too often the VA has failed to use the information provided by whistleblowers as an early warning system. Instead, in many cases the VA has ignored or attempted to minimize problems, allowing serious issues to fester and grow.

Our June 23 letter raised specific concerns about ten cases in which the VA admitted to serious deficiencies in patient care, yet implausibly denied any impact on veterans' health. As we stated in that communication, "The VA, and particularly the VA's Office of the Medical Inspector (OMI), has consistently used a 'harmless error' defense, where the Department acknowledges problems but claims patient care is unaffected." This approach hides the severity of systemic and longstanding problems, and has prevented the VA

from taking the steps necessary to improve quality of care for veterans.

To help illustrate the negative consequences of this approach, we will highlight three cases that were addressed in the June 23 letter.

1. *Ft. Collins, CO*

In response to a disclosure from a VA employee in Fort Collins, CO, OSC received an OMI report confirming severe scheduling and wait time problems at that facility. The report confirmed multiple violations of VA policies, including the following:

- A shortage of providers caused the facility to frequently cancel appointments for veterans. After cancellations, providers did not conduct required follow-up, resulting in situations where "routine primary care needs were not addressed."
- The facility "blind scheduled" veterans whose appointments were canceled, meaning veterans were not consulted when rescheduling the appointment. If a veteran subsequently called to change the blind-scheduled appointment date, schedulers were instructed to record the appointment as canceled at the patient's request. This had the effect of deleting the initial "desired date" for the appointment, so records would no longer indicate that the initial appointment was actually canceled by the facility, resulting in faulty wait time data.
- At the time of the OMI report, nearly 3,000 veterans were unable to reschedule canceled appointments, and one nurse practitioner alone had a total of 975 patients who were unable to reschedule appointments.
- Staff were instructed to alter wait times to make the waiting periods look shorter. Schedulers were placed on a "bad boy" list if their scheduled appointments were greater than 14 days from the recorded "desired dates" for veterans.

In addition, OSC is currently investigating reprisal allegations by two schedulers who were reportedly removed from their positions at Fort Collins and reassigned to Cheyenne, WY, for not complying with the instructions to "zero out" wait times. After these employees were replaced, the officially recorded wait times for appointments drastically "improved," even though the wait times were actually much longer than the officially recorded data. The chart below, which was provided in the report to OSC, clearly illustrates this phenomenon. After the new schedulers complied with orders to "zero out" wait times, the officially recorded percentage of veterans who were "scheduled within 14 days of [their desired date]" spiked to nearly 100%. There is no indication that actual wait times decreased.

Despite the detailed findings in their report, OMI concluded, "Due to the lack of specific cases for evaluation, OMI could not substantiate that the failure to properly train staff resulted in a danger to public health and safety." This conclusion is not only unsupportable on its own, it is also inconsistent with reports by other VA components examining similar patient-care issues. For example, the VA Office of Inspector General recently confirmed that delays in access to patient care for 1,700 veterans at the Phoenix Medical Center "negatively impacted the quality of care at the facility."

It is important to note that OSC first referred these allegations to the VA in October 2013, providing the VA with an opportunity to assess and begin to address the systemic scheduling abuses occurring throughout the VA health system. Yet, as discussed, the OMI report, which was issued in February 2014, failed to acknowl-

edge the severity of the identified problems, mischaracterized the concern as a "failure to properly train staff," and then did not consider how the inability to reschedule appointments impacted the health and safety of the 3,000 veterans who could not access care. There is no indication that the VA took any action in response to the deeply troubling facts outlined in the February 2014 report.

2. *Brockton, MA*

In a second case, a VA psychiatrist disclosed serious concerns about patient neglect in a long-term mental health care facility in Brockton, MA. The OMI report to OSC substantiated allegations about severe threats to the health and safety of veterans, including the following:

- A veteran with a 100 percent service-connected psychiatric condition was a resident of the facility from 2005 to 2013. During that time, he had only one psychiatric note written in his medical chart, in 2012, when he was first examined by the whistleblower, more than seven years after he was admitted. The note addressed treatment recommendations.
- A second veteran was admitted to the facility in 2003, with significant and chronic mental health issues. Yet, his first comprehensive psychiatric evaluation did not occur until 2011, more than eight years after he was admitted, when he was assessed by the whistleblower. No medication assessments or modifications occurred until the 2011 consultation.

Despite these findings, OMI would not acknowledge that the confirmed neglect of residents at the facility had any impact on patient care. Given the lack of accountability demonstrated in the first OMI report, OSC requested a follow-up report. The second report did not depart from the VA's typical "harmless error" approach, concluding: "OMI feels that in some areas [the veterans'] care could have been better but OMI does not feel that their patient's rights were violated." Such statements are a serious disservice to the veterans who received inadequate patient care for years after being admitted to VA facilities.

Moreover, in its initial referral letter to the VA, OSC noted that the whistleblower "believed these instances of patient neglect are an indication of large systemic problems present at the Brockton Campus." When the whistleblower was interviewed by OMI, the whistleblower stated his belief that these were not the only instances of neglect, and recommended that OMI examine all the patients receiving mental health care in the facility. However, when OMI was onsite, they limited the investigation to the three specific individuals treated by the whistleblower. OMI did not conduct a broader review. Additionally, there is no indication that the VA took action in response to the detailed factual findings in the OMI report, including ordering a broader review of patient neglect at Brockton or in other long-term mental health care facilities.

3. *Montgomery, AL*

Finally, in Montgomery, AL, an OMI report confirmed a whistleblower's allegations that a pulmonologist copied prior provider notes to represent current readings for veterans, likely resulting in inaccurate recordings of patient health information and in violation of VA rules. Rather than recording current readings, the pulmonologist copied and pasted the patients' earlier recordings from other physicians, including the patients' chief complaint, physical examination findings, vital signs, diagnoses, and plans of

care. Despite confirming this misconduct, OMI stated that it could not substantiate whether this activity endangered patient health. The timeline and specific facts indicate a broader lack of accountability and inappropriate responses by the VAMC leadership in Montgomery.

In late 2012, the whistleblower identified six instances in which a staff pulmonologist copied and pasted information from prior patient visits with other physicians. The whistleblower, a surgeon, was first alerted to the possible misconduct by an anesthesiologist during a veteran's preoperative evaluation prior to an operation.

The whistleblower reported these concerns to Alabama VAMC management in October 2012. In response to the whistleblower's report, VAMC management monitored the pulmonologist's medical record documentation practices. After confirming evidence of copying and pasting in medical records, the pulmonologist was placed on a 90-day "Focused Professional Practice Evaluation" (FPPE), or a review of the physician's performance at the VA. Despite additional evidence of improper copying and pasting of medical records during the 90-day FPPE, VAMC leadership ended the FPPE, citing satisfactory performance.

Meanwhile, the whistleblower brought his concerns to OSC, citing mismanagement by VAMC leadership in handling his complaint, and a threat to veterans' health and safety caused by the copied recordings.

OSC referred the allegations to the VA in April 2013. OMI initiated an investigation in May 2013. Despite confirming the underlying misconduct, OMI did not substantiate the whistleblower's allegations of mismanagement by VAMC leadership or threats to patient care. However, to its credit, OMI recommended that the Montgomery VAMC review all consults performed by the pulmonologist in 2011 and 2012, and not just the six known to the whistleblower.

Far worse than previously believed, the review determined that the pulmonologist engaged in copying and pasting activity in 1,241 separate patient records.

Despite confirming this widespread abuse, Montgomery VAMC leadership did not change its approach with the pulmonologist, who was again placed on an FPPE. Montgomery VAMC leadership also proposed a reprimand, the lowest level of available discipline.

OSC requested, and has not yet received, information from the VA to determine if the 1,241 instances of copying and pasting resulted in any adverse patient outcomes. Despite the lack of confirmation on this critical issue, Central Alabama VA Director James Talton publicly stated that the pulmonologist is still with the VA because there was no indication that any patient was endangered, adding that the physician's records are checked periodically to make sure no copying is occurring. As VA headquarters completes its review of the patient records, we encourage the VA to also review the specific actions taken by Montgomery VAMC leadership in response to the confirmed misconduct.

Beyond these specific cases, OSC continues to receive a significant number of whistleblower disclosures from employees at VA facilities throughout the country. We currently have over 60 pending cases, all of which allege threats to patient health or safety. OSC

has referred 28 of these cases to the VA for investigation. This represents over a quarter of all cases referred by OSC for investigation government-wide. Moving forward, it is critical that VA leadership, including the Office of the Secretary, review all whistleblower reports and proposed corrective actions to ensure that outcomes such as those described above are avoided.

III. Whistleblower Retaliation

1. Overview and scope of the problem

OSC has received scores of complaints from VA employees who say they have been retaliated against for blowing the whistle on improper patient scheduling, understaffing of medical facilities, and other dangers to patient health and safety at VA centers around the country. Based on the scope and breadth of the complaints OSC has received, it is clear that the workplace culture in many VA facilities is hostile to whistleblowers and actively discourages them from coming forward with what is often critical information.

OSC currently has 67 active investigations into retaliation complaints from VA employees. These complaints arise in 28 states and 45 separate facilities. Approximately 30 of these 67 cases have passed the initial review stage in our intake office, the Complaints Examining Unit, and are currently in our Investigation and Prosecution Unit, where they are being further investigated for corrective and disciplinary action. The number of cases increases daily. By way of example, OSC has received approximately 25 new whistleblower retaliation cases from VA employees since June 1, 2014.

2. Actions OSC has taken to investigate and address these cases

In addition to the ongoing investigation of nearly 70 retaliation cases, OSC has taken a number of steps to address and attempt to resolve these widespread complaints of whistleblower reprisal.

- OSC has reallocated staff and resources to investigating VA whistleblower reprisal cases. These cases are the office's highest priority and more than 30 attorneys and investigators are currently assigned to these whistleblower retaliation cases (in addition to all 14 employees in the Disclosure Unit). We have also implemented a priority intake process for VA cases.
- OSC representatives have met personally with VA officials in recent weeks, including Acting Secretary Gibson, Chief of Staff Jose Riojas, White House Deputy Chief of Staff Rob Nabors, attorneys from the Office of General Counsel, and others.
- OSC representatives recently traveled to Phoenix, Arizona to meet with FBI and VA Inspector General agents who are investigating the Phoenix VA cases, and also met with a number of the Phoenix VA whistleblowers.
- In addition to this testimony, OSC continues to brief the House and Senate Committees on Veterans Affairs on an ongoing basis, and provide information to individual Members of Congress who have concerns about disclosures or retaliation claims in their states or districts.

3. Examples of relief obtained

We cannot speak today about the details of ongoing reprisal cases, because doing so would jeopardize the integrity of the investigations and could improperly reveal the confidential identity of certain whistleblowers. However, we would like to mention a few cases where OSC has recently been able to obtain relief for whistleblowers:

An employee in a VA facility in Florida raised concerns about a number of issues, including poor patient care. The highlights of the employee's complaint are as follows:

- The employee had worked for the federal government for over two decades, including over 15 years with the VA. Throughout this lengthy service, the employee received "outstanding" and "excellent" job performance ratings and had never been disciplined.
- However, soon after the employee reported the poor patient care and other issues to the VA OIG in 2013, the VA removed certain of the employee's job duties and conducted a retaliatory investigation of the employee.
- Notably, in 2014, the VA also attempted to suspend the employee but OSC was able to obtain a stay of the suspension pending OSC's investigation of the matter.
- Due to the retaliatory environment, the employee decided to transfer to a VA facility in a different state in order to help protect the employee's job status and retirement benefits.

In a VA facility in New York, an employee complained to a supervisor about a delay in reporting a possible crime in the VA facility, as well as another serious patient care issue. The key points of the employee's complaint are as follows:

- Prior to blowing the whistle on this alleged misconduct, the employee received high job performance ratings as well as a bonus.
- However, soon after reporting the misconduct to a supervisor, this same supervisor informed the employee that an investigation into the employee's job performance would be conducted, which could result in the employee's termination. The basis for the investigation and possible termination was that the employee was "not a good fit for the unit."
- The investigation was set to convene in late June 2014, but OSC was recently able to obtain a stay pending OSC's investigation of the matter.

A VA employee in Hawaii blew the whistle after seeing an elderly patient improperly restrained in a wheelchair, which violated rules prohibiting the use of physical restraints without a doctor's order.

- Almost immediately after this disclosure, the employee was suspended for two weeks and received a letter of counseling.
- OSC investigated the matter and determined the VA had retaliated against the employee. As a result, OSC obtained corrective action for the employee, including a rescission of the suspension, full back pay, and an additional monetary award. At OSC's request, the VA also agreed to suspend the subject official who was responsible for the retaliation.

The severity of these cases underscores the need for substantial, sustained cooperation between the VA and OSC as we work to protect whistleblowers and encourage others to report their concerns.

IV. A New and Better Approach from the VA

While this has been a difficult period for the VA, it is important to note several encouraging signs from VA leadership suggesting a new willingness to listen to whistleblower concerns, act on them appropriately, and ensure that employees are protected for speaking out.

- In a June 13, 2014 statement to all VA employees, Acting Secretary Gibson specifically noted, "Relatively simple issues that front-line staff may be aware of can grow into significantly larger problems if left unresolved." We applaud Acting Secretary Gibson for recognizing the importance of whistleblower disclosures to improving the effectiveness and quality of health care for our veterans and for his commitment to identifying problems early in order to find comprehensive solutions.
- In response to OSC's June 23, 2014 letter to the President and Congress, Acting Secretary Gibson directed a comprehensive review of all aspects of the Office of Medical Inspector's operation. And, in response to OSC's recommenda-

tion, he stated his intent to designate an official to assess the conclusions and the proposed corrective actions in OSC reports. We look forward to learning about the results of the OMI review and believe the designated official will help to avoid the same problematic outcomes from prior OSC whistleblower cases.

• In their June 27, 2014 report to the President, Deputy White House Chief of Staff Rob Nabors and Acting VA Secretary Gibson confirmed that a review of VA responses to OSC whistleblower cases is underway, recommended periodic meetings between the Special Counsel and the VA Secretary, and recommended completion of OSC's whistleblower certification program as a necessary step to stop whistleblower retaliation. We look forward to working with the VA on the certification and training process.

• At a July 2014 meeting at OSC, Acting Secretary Gibson committed to resolving meritorious whistleblower retaliation cases with OSC on an expedited basis. We are hopeful this will avoid the need for lengthy investigations and help whistleblowers who have suffered retaliation get back on their feet quickly. In the very near future, we look forward to working out the details of this expedited review process and providing these whistleblowers with the relief and protection they deserve. Doing so will show employees that the VA's stated intolerance for retaliation is backed up by concrete actions. We will keep this Committee fully-informed on significant developments in this area.

V. Conclusion

In conclusion, we want to applaud the courageous VA employees who are speaking out. These problems would not have come to light without the information provided by whistleblowers. Identifying problems is the first step toward fixing them. We look forward to working closely with whistleblowers, the Committee, and VA leadership in the coming months to find solutions.

We would be pleased to answer any questions that the Committee may have.

PREPARED STATEMENT OF JAMES TUCHSCHMIDT

Good evening, Chairman Miller, Ranking Member Michaud, and Members of the Committee. Thank you for the opportunity to discuss whistleblower claims at the Department of Veterans Affairs (VA). I am accompanied today by Dr. Edward Huycke, Deputy Medical Inspector for the Veterans Health Administration's (VHA) Office of the Medical Inspector.

Our core values at VA are Integrity, Commitment, Advocacy, Respect, and Excellence—"I CARE." To get to excellence, we rely on the integrity, experience, observations, insights, and recommendations of VA's front-line staff, those who work professionally and compassionately with Veterans each and every day. We value that input and rely on it to help us better serve Veterans. Clearly, we are deeply concerned and distressed about the allegations that employees who sought to report deficiencies were either ignored, or worse, intimidated into silence. Let me be clear, VA will not tolerate an environment where intimidation or suppression of reports occurs.

Leaders are responsible for establishing a workplace atmosphere in which employees are comfortable highlighting and sharing their successes—as well as identifying areas in which we can improve. Whether that means notifying managers and supervisors of isolated gaps or bringing attention to larger, systemic issues that impede excellence, it is important that all employees are encouraged to report deficiencies in care or services we provide to Veterans. Relatively simple issues that front-line staff may be aware of can

grow into significantly larger problems if left unresolved. In the most serious cases, these problems can lead to and encourage improper and unethical actions.

Across VA, we expect workplace environments that protect the rights and enable full participation of all its employees. To that end, we have implemented biennial Workplace Harassment Prevention and the Notification and Federal Employee Antidiscrimination and Retaliation Act of 2002 (No FEAR Act) training for all 330,000+ employees VA-Wide to ensure they are aware and educated on their rights and responsibilities in these areas. We also recognize that supervisors and managers bear a heightened responsibility in maintaining a fair, safe, and inclusive culture. Accordingly, five years ago VA implemented additional mandatory Equal Employment Opportunity (EEO), Diversity & Inclusion, and Conflict Management training for all VA executives, managers, and supervisors VA-Wide. VA monitors compliance with this requirement on an on-going basis.

We expect employees to bring to the attention of their managers and supervisors shortcomings in the delivery of our services to Veterans, any perceived violations of law, rule or regulation, official wrongdoing, gross mismanagement, gross waste, fraud, abuse of authority, or any substantial and specific danger to public health or safety. Intimidation or retaliation against whistleblowers—or any employee who raises a hand to identify a legitimate problem, make a suggestion, or report what may be a violation of law, policy, or our core values—is absolutely unacceptable.

We all have a responsibility for enforcing appropriate workplace behavior. Protecting employees from reprisal is a moral obligation of VA leaders, a statutory obligation, and a priority for this Department. We will take prompt action to hold accountable those engaged in conduct identified as reprisal for whistleblowing, and that action includes appropriate disciplinary action. VA notifies all employees of their Whistleblower Protection rights annually in the Secretary's EEO, Diversity & Inclusion, No FEAR Act, and Whistleblower Protection Policy Statement.[1] We strongly encourage all supervisors to review this policy statement with their employees and ensure their full understanding. VA also conducts annual site visits to select facilities in the field to review their compliance with these policies and educate the leadership in these critical areas. Recently, we have taken steps to strengthen and expand the scope of these reviews and technical assistance visits.

Employees have several avenues of redress if they are confronted with whistleblower reprisal. Employees may file a complaint with the Office of Special Counsel (OSC) or appeal directly to the Merit Systems Protection Board. Employees are also always free to report whistleblower reprisal to a VA management official, to VA's independent Office of Inspector General (OIG), and to the Congress. VA emphasizes the importance of employees bringing their concerns forward and strongly encourages these actions. Each concern is taken seriously and addressed to the best extent possible.

We would like to address incidents where the OSC asks the Secretary of Veterans Affairs to conduct investigations into whistle-

[1] Available at http://www.diversity.va.gov/policy/statement.aspx.

blower cases about the Department. These are investigations conducted pursuant to 5 U.S.C. § 1213 and require VA to investigate and prepare a report of its investigation into the whistleblower disclosures. We take these investigations very seriously and they are undertaken immediately, as required by law. First, VA leaders are reminded of the mandate to protect whistleblowers from retaliation and other prohibited personnel practices. VA initially interviews the whistleblower, and follows up with him/her as often as necessary. Then, an investigation is conducted, which includes a site visit consisting of a document review, interview with individuals identified by the whistleblower, and any other appropriate individuals as determined by OMI. Reports generated by these investigations are reviewed and approved by VA leadership. VA facilities or program offices are required to complete action plans to address each report recommendation. VA tracks these action plans until completion. If appropriate progress is not apparent, subsequent onsite visits may be conducted. VHA will initiate administrative processes, when and where appropriate, to pursue disciplinary actions.

There is a second type of OSC whistleblower reprisal complaint that is investigated by OSC pursuant to 5 U.S.C. § 1214. In these cases, OSC works with VA to coordinate document discovery and interview requests with VA employees. If OSC finds there is sufficient evidence to support an allegation of a prohibited personnel practice, VA works with OSC to develop a meaningful way to resolve the complaint, normally through a settlement agreement between the whistleblower and VA. If a resolution is not reached, OSC may seek remedial action by filing an appeal against the Department with the Merit Systems Protection Board.

On June 23, 2014, OSC sent a letter regarding complaints about VA care across the country. In response to the OSC letter, Acting Secretary Gibson directed a comprehensive review of all aspects of the Office of Medical Inspector's operation. The VA Medical Inspector, John Pierce, M.D., has retired. Acting Secretary Gibson has met with Special Counsel Carolyn Lerner and a number of other staff-level meetings have also occurred. VA intends to regularly meet with OSC officials. We welcome OSC's insights, and we look forward to working closely with its staff to improve our process and culture regarding whistleblower complaints going forward.

VA is committed to making the changes necessary to ensure that we, in conjunction with OSC and OIG, properly investigate all allegations. We also will not tolerate retaliation against any employee who raises a hand to identify a legitimate problem or suggest a solution.

Conclusion

Mr. Chairman, we will continue to depend on the service of VA employees and leaders who place the interests of Veterans above and beyond self-interest; who serve Veterans with dignity, compassion, and dedication; who live by VA's core values of Integrity, Commitment, Advocacy, Respect, and Excellence; and who have the moral courage to help us serve Veterans better by helping make our policy and procedures better. I assure you that VA takes these issues very seriously and will do everything possible to ensure we cultivate an environment that empowers our employees and demands accountability in service to our Veterans. Mr. Chairman,

this concludes my testimony. My colleague and I are now prepared to answer your questions.

MATERIALS SUBMITTED FOR THE RECORD

LETTER TO HON. MILLER FROM DVA, INSPECTOR GENERAL

Dear Mr. Chairman:

I respectfully request that this letter be included in the record for the July 8, 2014, hearing before the Committee entitled, "VA Whistleblowers: Exposing Inadequate Service Provided to Veterans and Ensuring Appropriate Accountability." At that hearing information was provided by two witnesses that was not accurate regarding the Office of Inspector General (OIG).

a. *Dr. Katherine Mitchell on Claimed Disclosures to the OIG*—Dr. Mitchell testified that she submitted a confidential OIG complaint in September 2013 regarding life-threatening conditions at the Phoenix VA Health Care System and that approximately 10 days after the national VA received her report she was placed on administrative leave for a month. She further testified that she was disciplined for misconduct for providing confidential information through the OIG channels. Her testimony is inaccurate in regard to her interactions with the OIG. The OIG first received information relating to complaints by Dr. Mitchell in April 2014, and that information was provided by the Senate Committee on Veterans' Affairs, not Dr. Mitchell. We determined through inquiries with relevant congressional and VA staff that Dr. Mitchell submitted her complaint to the office of Senator John McCain in September 2013, and that Senator McClain's office sent that information to the VA Congressional Liaison Service. VA's Congressional Liaison Service assigned the correspondence to the Veterans Health Administration (VHA) and an investigative team from the Veterans Integrated Service Network 18 was tasked with conducting an investigation into her allegations. The OIG was not aware of and did not participate in any review or investigation conducted by VHA. Dr. Mitchell's testimony implies that the OIG breached her confidentiality, which is simply untrue because she did not file a complaint with the OIG in September 2013.

b. *Dr. Mitchell on Providing Protected Information to the OIG*—Dr. Mitchell further states in her written testimony that "Disclosure of pertinent patient care information in support of whistle-blower activity through approved channels of VA oversight is not a patient privacy violation" and further states "Unfortunately, the Office of Inspector General has declined thus far to put that opinion in writing." Her statement regarding the OIG is not accurate because Dr. Mitchell never asked the OIG to put such a statement in writing. While Dr. Mitchell may be unaware, the OIG has provided both written and verbal advice to complainants and other employees that they can legally provide protected information to the OIG. As recently as June 25, 2014, we addressed this issue in our response to a June 20, 2014, letter sent by the American Federation of Government Employees (AFGE) to Mr. William Gunn, former VA General Counsel. Copies of this response were sent to the Chairman and Ranking Members of the House and Sen-

ate Committees on Veterans' Affairs. A copy of the letter from AFGE and our response are attached.

c. *Dr. Mitchell on Publication of Reports Involving VA Senior Executives*—Dr. Mitchell testified during the hearing regarding OIG policy for releasing reports on members of VA's Senior Executives either on our Web site or through our Release of Information office. She also stated that neither she nor Senator McCain had been able to obtain a copy of an investigation. Similar testimony was provided by Dr. Christian Head. I can assure you that the OIG follows all applicable laws and rules regarding release of information in both forums. Reports dealing with allegations of misconduct by VA employees are posted on the OIG's public Web site. All reports are identified on our Web site within 3 days of being issued as required by the Inspector General Act. Unless we have received a request under the Freedom of Information Act (FOIA), to comply with applicable confidential legal requirements, only the title of the report and other summary information are posted on our Web site. However once the requisite number of FOIA requests are received, a redacted report is posted on our Web site.

To comply with FOIA and applicable case law, it is our practice to redact the names of employees and other individuals below the GS–15 level. When the issues in the report relate directly to an employee's duties and responsibilities, applying the analysis required under FOIA, it is usually determined that the individual's right to privacy is outweighed by the public's right to know for employees at or above the GS–15 level. In those instances, the names are not redacted when the report is posted on the OIG website. In the last 7 years, we have published on our website 33 reports of administrative investigations, of which 16 included substantiated allegations against one or more members of the Senior Executive Service whose names were fully disclosed in the reports. Dr. Mitchell's testimony that neither she nor Senator McCain have been able to obtain a copy of a report relating to her complaint and that the OIG was stonewalling Senator McCain is also inaccurate because, as noted above, her complaint was not forwarded to the OIG. In addition, after listening to the testimony, we reviewed our files and have no record of any request by Dr. Mitchell or Senator McCain for a report or any other records relating to Dr. Mitchell.

d. *Dr. Mitchell on the OIG's Phoenix Office*—Dr. Mitchell also made comments during her testimony that the OIG staff assigned to the Phoenix area had a history of not conducting good investigations. The basis for her statement is not clear since she has not been involved in any of the investigations conducted by that office. The OIG's only presence in Phoenix is an Office of Investigations Resident Agency office on the campus of the medical center staffed with four Criminal Investigators who are highly trained, competent, and objective. If Dr. Mitchell would have contacted them, they would have followed OIG procedures for reviewing a complaint and would have protected her confidentiality. It is not uncommon for VA employees in Phoenix to contact our onsite Criminal Investigators either in-person or by telephone when they have concerns. In the past 5 years, the work conducted by the Phoenix OIG office has resulted in 192 arrests, 108 administrative actions, and $9.4

million in monetary recoveries. These statistics refute the assertion that the OIG office in Phoenix does not conduct good investigations.

e. *Dr. Head on a Prior OIG Administrative Investigation*—Dr. Head made comments in his testimony relating to his participation in an OIG administrative investigation that needs to be clarified. Dr. Head stated that he received a subpoena from the OIG to testify in a case, which is not correct. With the exception of the Department of Defense OIG, no Federal OIG has testimonial subpoena power. The subpoena authority granted to Inspectors General under the Inspector General Act is limited to records. When conducting an investigation, we notify VA employees that we want to conduct an interview with the expectation that they will appear for the interview as required by VA regulation. Although the regulation provides that the failure to cooperate with an official investigation may result in a disciplinary action, the VA OIG has no authority to propose or take such an action.

The investigative report cited by Dr. Head, which was issued in March 2007, is identified on our website but as a restricted report. Information in the report, including the identity of the individuals who were the subjects of the investigation, is protected from disclosure under the Privacy Act. Without a FOIA request, we are prohibited by law from releasing the information in the report as it relates to individuals identified in the report. We have no record of a FOIA request by Dr. Head or anyone else for this report. Had we received a request, the report would have been reviewed for release under FOIA. Also, Dr. Head testified that medical center management did not follow the recommendations of the OIG to take a specific administrative action. As we have advised the Committee in the past, the OIG does not make recommendations to VA in our reports to take a specific administrative action because a concurrence by VA on the report would deprive the employee of his or her right to due process.

The OIG takes seriously its mission to review allegations of poor quality of care and goes to great lengths to protect all sources of information who request confidentiality as required by the Inspector General Act.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

Richard J. Griffin, Acting Inspector General

LETTER TO AFGE FROM DVA, INSPECTOR GENERAL

Dear Mr. Borer:

I am responding on behalf of Mr. Richard J. Griffin, the Acting Inspector General, to your June 13, 2014, letter to Mr. William Gunn, addressing the disclosure of medical information by whistleblowers to the Department of Veterans Affairs Office of Inspector General (VA OIG) and the Office of Special Counsel. Based on our review of the applicable laws, I believe that the VA OIG may be the only entity with the authority to investigate allegations relating to patient care to which VA employees can legally provide medical and other protected information and remain confidential.

Your letter primarily addresses issues relating to the disclosure of medical information protected under the Health Insurance Portability and Accountability Act (HIPAA). With regard to HIPAA, the implementing regulations specifically permit disclosures to "a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections. . . . " 45 CFR Section 164.512 (d). Section 164.502 (G) addresses disclosures by workforce members and business associates who are whistleblowers. This section allows for disclosure if the individual:

Believes in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public.

However, the disclosure must be made to a:

Health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the covered entity or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the covered entity. . . .

The VA OIG has been determined to be a health oversight agency for the purposes of these regulatory provisions. Therefore, any disclosure of HIPAA protected records would be authorized.

However, in addition to HIPAA, there are other statutes that prohibit the disclosure of VA medical records. These statutes have associated criminal penalties for wrongful disclosure. In addition to the Privacy Act, 5 U.S.C. Section 552, other relevant statutes that can be found in Title 38 of the United States Code include: Section 5701, which protects veterans claims records (including medical records), Section 5705, which protects medical quality assurance records, and Section 7732, which protects records relating to the diagnosis and treatment of drug and alcohol abuse, HIV, and sickle cell anemia. As discussed below, VA employees and contractors can provide these protected records or information obtained from these records to the VA OIG, without violating any of these statutes.

The Inspector General Act specifically states that the Inspector General has access to all agency records. 5 U.S.C. App. Section 6. Neither HIPAA nor any of the statutes cited above prohibits the disclosure of medical records to the VA OIG. Accordingly, an employee can legally provide any VA record to the VA OIG.

The Whistleblower Protection Act (WPA) prohibits officials from taking, threatening to take, or failing to take a personnel action with respect to any employee or applicant because of: "Any disclosure to the Special Counsel or the Inspector General of an agency. . . . " 5 U.S.C. Section 2302 (b)(8)(B). This subsection of the WPA does not include any restrictions on the nature of the information provided to the Inspector General or the Special Counsel. In contrast, the statute states that disclosures to other entities are only protected if the "disclosure is not specifically prohibited by law and if such information is not specifically required by Executive Order

to be kept secret. . . . " 5 U.S.C. Section 2302 (b)(8)(A). This section also makes it a prohibited personnel practice to take, threaten to take, or fail to take any personnel action against any employee for "cooperating with or disclosing information to the Inspector General of an agency or the Special Counsel in accordance with the applicable provisions of law." 5 U.S.C. Section 2302 (b)(8)(C). This last provision not only protects employees who file a complaint with the VA OIG, it also protects employees who cooperate with a VA OIG investigation, audit, or other review and who provide information to us during those reviews.

We understand that employees are reluctant to make disclosures for fear of retaliation. The Inspector General Act also mandates that the VA OIG maintain the confidentiality of employees and others who file a complaint or otherwise bring information to our attention. 5 U.S.C. App. Sections 7 and 8L. When employees contact the VA OIG Hotline they are advised of their right to remain confidential or be anonymous and, if they choose to waive these rights, are asked to do so in writing.

As noted above, the VA OIG has the authority to investigate allegations of wrongdoing in the VA. While, like the VA OIG, the Office of Special Counsel's (OSC) Disclosure Unit has the authority to receive allegations of violations of law, rule, or regulation or gross mismanagement of funds, an abuse of authority, or a substantial and specific danger to public health or safety, OSC has no authority to investigate these claims. If after reviewing the information OSC determines that an investigation is warranted, OSC is required to transmit the information to the appropriate agency head for investigation. 5 U.S.C. Section 1213. Although OSC will not identify the complainant if confidentiality is requested, this may impact the agency's ability to conduct a thorough and comprehensive investigation of the issues.

As you note in your letter, our reports may state that an allegation cannot be substantiated. In some cases this is because we obtained and reviewed additional information that refutes an allegation. In other cases, this is because the complainant has not provided sufficient information on which to base an investigation. When an employee submits a complaint to the VA OIG and requests confidentiality, we contact that individual to obtain any additional information he or she may have regarding their complaint, which may include records that the employee may not have identified or submitted due to concerns about the confidentiality of the records. This allows the VA OIG to conduct a more thorough and complete investigation without disclosing the identity of the source of the information than may be possible if the complainant is anonymous or the matter is referred to the VA OIG through a third party and the identity of the complainant is unknown.

I hope this addresses your concerns about the legal implications relating to the disclosure of protected information to the VA OIG.

Sincerely,

MAUREEN REGAN, Counselor to the Inspector General

The Honorable Sloan Gibson, Acting Secretary, Department of Veterans Affairs; The Honorable Carolyn Lerner, Office of Special Counsel

The Honorable Bernie Sanders, U.S. Senate, Chair, Committee on Veterans' Affairs; The Honorable Jeff Miller, Chair, House Veterans' Affairs Committee

The Honorable Michael Michaud, Ranking Member, House Veterans' Affairs Committee; The Honorable Richard Burr, Ranking Member, U.S. Senate, Committee on Veterans' Affairs

The Honorable Rob Nabors, White House Deputy Chief of Staff; The Honorable W. Neil Eggleston, White House Counsel

The Honorable Sylvia Mathews Burwell, Secretary of Health and Human Services; The Honorable Eric H. Holder, Jr., Attorney General

Mr. J. David Cox, Sr., National President AFGE, Ms. Alma Lee, Council President, NVAC

LETTER TO PRESIDENT OBAMA FROM HON. CAROLYN LERNER

Dear Mr. President:

I am providing you with the U.S. Office of Special Counsel's (OSC) findings on whistleblower disclosures from employees at the Veterans Affairs Medical Center in Jackson, Mississippi (Jackson VAMC). The Jackson VAMC cases are part of a troubling pattern of responses by the Department of Veterans Affairs (VA) to similar disclosures from whistleblowers at VA medical centers across the country. The recent revelations from Phoenix are the latest and most serious in the years-long pattern of disclosures from VA whistleblowers and their struggle to overcome a culture of non-responsiveness. Too frequently, the VA has failed to use information from whistleblowers to identify and address systemic concerns that impact patient care.

As the VA re-evaluates patient care practices, I recommend that the Department's new leadership also review its process for responding to OSC whistleblower cases. In that regard, I am encouraged by the recent statements from Acting Secretary Sloan Gibson, who recognized the significant contributions whistleblowers make to improving quality of care for veterans. My specific concerns and recommendations are detailed below.

Jackson VAMC

In a letter dated September 17, 2013, I informed you about numerous disclosures regarding patient care at the Jackson VAMC made by Dr. Phyllis Hollenbeck, Dr. Charles Sherwood, and five other whistleblowers at that facility. The VA substantiated these disclosures, which included improper credentialing of providers, inadequate review of radiology images, unlawful prescriptions for narcotics, noncompliant pharmacy equipment used to compound chemotherapy drugs, and unsterile medical equipment. In addition, a persistent patient-care concern involved chronic staffing shortages in the Primary Care Unit. In an attempt to work around this issue, the facility developed "ghost clinics." In these clinics, veterans were scheduled for appointments in clinics with no assigned

provider, resulting in excessive wait times and veterans leaving the facility without receiving treatment.

Despite confirming the problems in each of these (and other) patient-care areas, the VA refused to acknowledge any impact on the health and safety of veterans seeking care at the Jackson VAMC. In my September 17, 2013 letter, I concluded:

"[T]he Department of Veterans Affairs (VA) has consistently failed to take responsibility for identified problems. Even in cases of substantiated misconduct, including acknowledged violations of state and federal law, the VA routinely suggests that the problems do not affect patient care."

A detailed analysis of Dr. Hollenbeck's and Dr. Sherwood's disclosures regarding patient care at the Jackson VAMC is enclosed with this letter. I have also enclosed a copy of the agency reports and the whistleblowers' comments.

Ongoing Deficiencies in VA Responses to Whistleblower Disclosures

OSC continues to receive a significant number of whistleblower disclosures from employees at VA facilities throughout the country. We currently have over 50 pending cases, all of which allege threats to patient health or safety. I have referred 29 of these cases to the VA for investigation. This represents over a quarter of all cases referred by OSC for investigation government-wide.

I remain concerned about the Department's willingness to acknowledge and address the impact these problems may have on the health and safety of veterans. The VA, and particularly the VA's Office of the Medical Inspector (OMI), has consistently used a "harmless error" defense, where the Department acknowledges problems but claims patient care is unaffected. This approach has prevented the VA from acknowledging the severity of systemic problems and from taking the necessary steps to provide quality care to veterans. As a result, veterans' health and safety has been unnecessarily put at risk. Two recent cases illustrate the negative consequences of this approach.

First, in response to a disclosure from a VA employee in Fort Collins, CO, OSC received an OMI report confirming severe scheduling and wait time problems at that facility. The report confirmed multiple violations of VA policies, including the following:

- A shortage of providers caused the facility to frequently cancel appointments for veterans. After cancellations, providers did not conduct required follow-up, resulting in situations where "routine primary care needs were not addressed."
- The facility "blind scheduled" veterans whose appointments were canceled, meaning veterans were not consulted when rescheduling the appointment. If a veteran subsequently called to change the blind-scheduled appointment date, schedulers were instructed to record the appointment as canceled at the patient's request. This had the effect of deleting the initial "desired date" for the appointment, so records would no longer indicate that the initial appointment was actually canceled by the facility.
- At the time of the OMI report, nearly 3,000 veterans were unable to reschedule canceled appointments, and one nurse practitioner alone had a total of 975 patients who were unable to reschedule appointments.
- Staff were instructed to alter wait times to make the waiting periods look shorter.
- Schedulers were placed on a "bad boy" list if their scheduled appointments were greater than 14 days from the recorded "desired dates" for veterans.

In addition, OSC is currently investigating reprisal allegations by two schedulers who were reportedly removed from their positions at Fort Collins and reassigned to Cheyenne, WY, for not complying with the instructions to "zero out" wait times. After these employees were replaced, the officially recorded wait times for appointments drastically "improved," even though the wait times were actually much longer than the officially recorded data.

Despite these detailed findings, the OMI report concluded, "Due to the lack of specific cases for evaluation, OMI could not substantiate that the failure to properly train staff resulted in a danger to public health and safety." This conclusion is not only unsupportable on its own, but is also inconsistent with reports by other VA components examining similar patient-care issues. For example, the VA Office of Inspector General recently confirmed that delays in access to patient care for 1,700 veterans at the Phoenix Medical Center "negatively impacted the quality of care at the facility."

In a second case, a VA psychiatrist disclosed serious concerns about patient neglect in a long-term mental health care facility in Brockton, MA. The OMI report substantiated allegations about severe threats to the health and safety of veterans, including the following:

A veteran with a 100 percent service-connected psychiatric condition was a resident of the facility from 2005 to 2013. In that time, he had only one psychiatric note written in his medical chart, in 2012, when he was first examined by the whistleblower, more than seven years after he was admitted. The note addressed treatment recommendations.

A second veteran was admitted to the facility in 2003, with significant and chronic mental health issues. Yet, his first comprehensive psychiatric evaluation did not occur until 2011, more than eight years after he was admitted, when he was assessed by the whistleblower. No medication assessments or modifications occurred until the 2011 consultation.

Despite these findings, OMI failed to acknowledge that the confirmed neglect of residents at the facility had any impact on patient care. Given the lack of accountability demonstrated in the first OMI report, OSC requested a follow-up report. The second report did not depart from the VA's typical "harmless error" approach, concluding: "OMI feels that in some areas [the veterans'] care could have been better but OMI does not feel that their patient's rights were violated." Such statements are a serious disservice to the veterans who received inadequate patient care for years after being admitted to VA facilities.

Unfortunately, these are not isolated examples. Rather, these cases are part of a troubling pattern of deficient patient care at VA facilities nationwide, and the continued resistance by the VA, and OMI in most cases, to recognize and address the impact on the health and safety of veterans. The following additional examples illustrate this trend:

- In Montgomery, AL, OMI confirmed a whistleblower's allegations that a pulmonologist copied prior provider notes to represent current readings in over 1,200 patient records, likely resulting in inaccurate patient health information being recorded. OMI stated that it could not substantiate whether this activity endangered patient health.

- In Grand Junction, CO, OMI substantiated a whistleblower's concerns that the facility's drinking water had elevated levels of Legionella bacteria, and standard maintenance and cleaning procedures required to prevent bacterial growth were not performed. After identifying no "clinical consequences" resulting from the unsafe conditions for veterans, OMI determined there was no substantial and specific danger to public health and safety.
- In Ann Arbor, MI, a whistleblower alleged that employees were practicing unsafe and unsanitary work practices and that untrained employees were improperly handling surgical instruments and supplies. As a result, OMI partially substantiated the allegations and made 12 recommendations. Yet, the whistleblower informed OSC that it was not clear whether the implementation of the corrective actions resulted in better or safer practices in the sterilization and processing division. OMI failed to address the whistleblower's specific continuing concerns in a supplemental report.
- In Buffalo, NY, OMI substantiated a whistleblower's allegation that health care professionals do not always comply with VA sterilization standards for wearing personal protective equipment, and that these workers occasionally failed to place indicator strips in surgical trays and mislabeled sterile instruments. OMI did not believe that the confirmed allegations affected patient safety.
- In Little Rock, AR, OMI substantiated a whistleblower's allegations regarding patient care, including one incident when suction equipment was unavailable when it was needed to treat a veteran who later died. OMI's report found that there was not enough evidence to sustain the allegation that the lack of available equipment caused the patient's death. After reviewing the actions of the medical staff prior to the incident, OMI concluded that the medical care provided to the patient met the standard of care.
- In Harlingen, TX, the VA Deputy Under Secretary for Health confirmed a whistleblower's allegations that the facility did not comply with rules on the credentialing and privileging of surgeons. The VA also found that the facility was not paying fee-basis physicians in a timely manner, resulting in some physicians refusing to care for VA patients. The VA, however, found that there was no substantial and specific danger to public health and safety resulting from these violations.
- In San Juan, PR, the VA's Office of Geriatrics and Extended Care Operations substantiated a whistleblower's allegations that nursing staff neglected elderly residents by failing to assist with essential daily activities, such as bathing, eating, and drinking. OSC sought clarification after the VA's initial report denied that the confirmed conduct constituted a substantial and specific danger to public health. In response, the VA relented and revised the report to state that the substantiated allegations posed significant and serious health issues for the residents.

Next Steps

The goal of any effective whistleblower system is to encourage disclosures, identify and examine problem areas, and find effective solutions to correct and prevent identified problems from recurring. Acting Secretary Gibson recognized as much in a June 13, 2014, statement to all VA employees. He specifically noted, "Relatively simple issues that front-line staff may be aware of can grow into significantly larger problems if left unresolved." I applaud Acting Secretary Gibson for recognizing the importance of whistleblower disclosures to improving the effectiveness and quality of health care for our veterans and for his commitment to identifying problems early in order to find comprehensive solutions.

Moving forward, I recommend that the VA designate a high-level official to assess the conclusions and the proposed corrective actions in OSC reports, including disciplinary actions, and determine if the substantiated concerns indicate broader or systemic problems requiring attention. My staff and I look forward to working closely with VA leadership to ensure that our veterans receive the quality health care services they deserve.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the agency reports and whistleblowers' comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted reports and the whistleblowers' comments in OSC's public file, which is available online at www.osc.gov.

Respectfully,
Carolyn N. Lerner, President

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